What can be learnt from offering therapeutic work to parents and infants (under the age of five) in a Child and Adolescent Mental Health Service (CAMHS) clinic that does not routinely offer this type of intervention?

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Abstract

This project set out to explore how a model of brief parent-child psychotherapy, involving children under the age of five, could be applied in a Child and Adolescent Mental Health Service (CAMHS) clinic which does not routinely offer therapeutic intervention to this age group. I hoped to learn about how the work would be received by both service users, as well as by colleagues. The literature review revealed extensive contributions from both theoretical and clinical perspectives, highlighting the evidence base for parent-child psychotherapy with young children, and focusing primarily on brief models of intervention.

Five families were each offered five parent-child psychotherapy sessions, based on the Tavistock Under-Fives model, and data was gathered and analysed from both the clinical intervention and from interviews and standardised outcome measures. Thematic analysis revealed interesting themes, including ideas relating to communication and connection, physical expression and roles.

At the end of treatment, parents appeared increasingly able to think about their child's difficulties and needs within the context of the family. Feedback gained through outcome measures and the therapy sessions indicated that generally the parents found the intervention helpful and they were pleased to have taken part. There was, however, because of the time limited nature of the project, a desire for continued therapeutic intervention, which suggests that increased flexibility, in terms of the duration of treatment, would be helpful in future work.

Despite the intervention being brief, change and an increased capacity to think about the child's communication and wellbeing was evident. The intervention informed ongoing liaison between professionals, something which emerged as an important finding. An increasing interest in work with young children was evident from the families, my colleagues and other professionals. Recommendations regarding the potential development and expansion of this model are also made in this thesis.

Contents

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Introduction

i. Aims

The title of this project is ‘What can be learnt from offering therapeutic work to parents and infants (under the age of five) in a Child and Adolescent Mental Health Service (CAMHS) clinic that does not routinely offer this type of intervention?’. The project set about to trial a brief method of working with children under the age five years old, and their parents together, in order to learn about the practicalities and implications of this kind of work.

I started this project with the assumption that brief parent-child psychotherapy has been widely used with successful impact. I wanted, therefore, to learn more about how this way of work could be incorporated into a busy CAMHS team, in a geographical area which does not have a designated ‘under-fives service’ and does not generally offer targeted therapeutic support to young children (and their parents). There were two main aims for the project; the first was to find out how the families involved received the intervention and to learn about the kinds of themes and topics of discussion which emerged during the work. This was done making using of qualitative research methods. Secondly, as this method of working was new in the service, I hoped to gather some information about how my colleagues responded to the model. Gathering full qualitative or quantitative data in this area was beyond the scope of the project, so instead I aimed to informally capture some reflections on how the model was received by the team.

ii. Rationale

Child and adolescent psychotherapists are trained to work with children of all ages, from birth up to late adolescence. The Association of Child Psychotherapists' (ACP) website (ACP, 2017) explained that a psychotherapist's job is to develop an understanding of '*the complex emotional lives of infants, children, young people, families and carers in depth'*. The training to become a psychoanalytic psychotherapist involves gaining experience of working with children of all ages, including intensive work (typically involving seeing a child three times a week) with a child under the age of five; a child of latency age; and an adolescent. Furthermore, amongst the various workshops offered during the training, there is an Infant Mental Health workshop, which explores different aspects of infant mental health by means of guest speakers, reviewing literature and sharing clinical examples of work that we, as trainees, carry out in our training posts.

The ACP provide information about the ways in which these different age groups can be worked with. In their 'Child psychotherapy in the early years' briefing paper (ACP, no date) three main types of work are mentioned; specialist assessments, therapeutic work and consultation, or training. Psychotherapists are, therefore, well trained and practised in working with young children in various ways, and we can use our skills in observation and the tools of our transference and counter-transference to try and help understand both the conscious and unconscious communications from both the child and the parent(s).

During my training, I found myself feeling increasingly interested in the younger age group, and this got me thinking about how difficulties in this age group were thought about and responded to by the CAMHS team in which I was working. On an observational level, it was clear from looking in the waiting room and attending referral screening meetings that younger children (although it is difficult to quantify this age group exactly) did not make up a very large percentage of our overall intake. I wondered whether mental health problems are simply more prominent in older children, or whether there are difficulties in the younger age group, but for some reason they either do not get referred, or do not get offered treatment.

Whilst working in a CAMHS clinic, I frequently came across children who had been in and out of the mental health system, some for many years. I have heard about the difficulties of accessing support when the child was young, and some uncertainties about knowing how best to respond to the mental health needs of younger children. It is, unfortunately, a reality that often children are referred to CAMHS when they are of a latency age, and sometimes we see these children requiring on-going mental health support for several years, which is in part owing to the chronic and complex nature of their difficulties.

Klauber (1998) described how families might '*become trapped in the same systems, clinging to predictability and routine at the expense of all spontaneity'* (p. 88). With this in mind, I began to think about what role early, more preventative work, with young children and their parents could play within the mental health service. I wondered whether work with younger children when the problems began (rather than when they were entrenched and long-standing) might be an effective way of tackling some difficulties the child might be experiencing and could potentially help to reduce long-term involvement with mental health and support services.

On a practical level, CAMHS services are stretched and under resourced, and often older, risky children are seen most frequently. Children's risks are assessed and those deemed to have the highest risks are prioritised for intervention. Whilst this of course makes sense, it does, sadly, leave little space for what could be described as more preventative work objectively with lower risk children. It could be suggested that implementing short-term work for younger children, to help both the child and the parents, could function as a method of tackling *some* of the challenges and difficulties which face our families, so the risks do not escalate as drastically.

The changing role of Tier 2 workers may have contributed to the evolving role of CAMHS because, whilst previously these clinicians did much of their work within the community, offering preventative or low-level support, they are now predominantly based within the CAMHS clinic. It seemed to me that it was important to try to think about short-term methods of working in a psychodynamic context, in order to try and reach families and offer some support.

After considering this with my team, I began some conversations with local health visitors, as I knew that they would have a good grasp of the current needs and challenges facing the younger age group. Maggie Harris (2007) discussed the important role which health visitors can play in therapeutic interventions with young children, owing to their knowledge and expertise in child development, their ability to observe and, also, the pre-existing relationship they have with families, which can provide a '*secure base'* (p. 193) for therapeutic work. The health visiting teams do, therefore, have a lot to offer when considering work with young children.

My initial discussions took place with the health visitor lead for the local area. I talked to her, by telephone, about my interests in infant mental health and I asked for her views and experiences of liaising with CAMHS and accessing support for this younger age group.

I was unsurprised to hear that the health visitors recognised that there were younger children in need of specialist mental health support. However, it seemed that it was often their experience that these children were said not to meet the criteria for CAMHS intake and were referred back to the health visitors. The health visitors described feeling left trying to manage complex and difficult situations on their own; and whilst they are well trained and knowledgeable professionals, they recognised that some children (and families) require something more specialist, in terms of their mental health.

I felt concerned by these conversations with health visiting colleagues, and I began to consider how my doctoral project might be able to address this gap and learn more about ways of working with younger children which could be made use of in the local CAMHS service.

The CAMHS team in which I work adopted the THRIVE model of working in the last few years (CAMHS Press, 2014). This model addresses how CAMHS services are delivered, and divides support and intervention into four categories: ‘Getting Advice’, ‘Getting Help, ‘Getting More Help’ and ‘Getting Risk Support’. The implementation of this model coincided with the planning stages of my research project; and I decided that I wanted to offer an intervention which would fall within the ‘Getting Help’ category of the THRIVE model.

During the initial planning stages, I contacted an assistant psychologist who had conducted an audit, gathering data regarding referrals for 0-5 year olds into the six CAMHS teams within the Trust, between 2015 and 2016. Of the 5214 referrals received, only 48 of these were for children under the age of five, which equates to

0.9% of all received referrals. Of these 48 referrals, only seven were ‘taken-up’, and following assessment they were offered either an attachment focused intervention, or were screened for ASD. The main reason for the other 41 not being taken up was that it was deemed that there was no significant mental health need present, and they were generally signposted to another agency; including health visitors, domestic violence teams, paediatrics, social care and self-help.

This data was very interesting to me, and I was surprised by both the very small number of referrals received, and how many of these were not accepted. It was puzzling that so many of these referred children were deemed not to have significant mental health needs. Unfortunately, I was not provided equitant data for other age groups, as it would have been interesting to know whether similar patterns emerged in the older age groups; or whether there is something about the way in which difficulties are viewed, or categorised, which is specific to this young age group. I have wondered whether mental health difficulties are harder to recognise in younger children, or whether there is, perhaps, a reluctance to accept that there may even be such difficulties in this age group.

After careful consideration and discussions with my course leaders and my clinical supervisor, I decided that I wanted to run a pilot, offering brief therapeutic interventions to children under the age of five, and their families. Whilst in the early planning stages, I contacted the health visiting team again and asked whether I could meet with them, to introduce the plan for my project. In response, I was invited to the bi-monthly county-wide health visitor meeting.

In this meeting, I was given a short presentation slot, where I introduced myself, my training and my interest in infant mental health. I explained that I was hoping to run a project offering brief parent-child work within the local CAMHS service and my hope was to develop links with their team. Only a brief discussion followed my presentation, and this mainly centred around one or two health visitors asking how to refer children to the project. I explained to them that, unfortunately, at that stage recruitment was not open, but I encouraged them to keep in contact with the CAMHS team about potential referrals.

I will now give an overview of the wider context in which this work sits.

iii. The wider context

Melanie Klein was a bold advocate for the ability to engage children in psychoanalytic analysis, based on the same principles as adult analysis (1927). In fact, in terms of unconscious communication, Klein suggested that, with children, there is a much closer link between conscious and unconscious processes and the therapist is, therefore, easily able to work with and interpret both, predominantly through the child's play (1926). Parent-child psychotherapy, therefore, aims to work with the *'flow of conscious and unconscious communications'* (Emanuel, 2011:673) from both the parent(s) and the child(ren).

One of the tools which psychotherapists make use of is the ability to observe, a skill which begins during the training, when all students have to carry out weekly observations of an infant (for two years) and a young child (for one year). In Esther Bick's (1964) description of infant observation, she highlighted how the focus is on the baby, but there is also an awareness and observation of the parents too, which is unavoidable. We could say the same for psychotherapy with children, that whilst our primary focus may be the child, we must also pay some attention and focus to the parents too. Whilst there are different ways of attending to these different needs, such as offering the parent sessions alongside their child’s individual work; the model of parent-child psychotherapy broadens the lens, and tries to keep parent and child in mind throughout.

Across the country, services have been developed in order to address the mental health needs of young children, and many of these promote therapeutic work with both the child and the parents together.

The Under-Fives Counselling Service was developed at the Tavistock Clinic in the 1980s, with key contributions from Lisa Miller and Alan Shuttleworth (Pozzi-Monzo and Tydeman, 2007), among others. Since then, this kind of work, with parents and infants has continued and has become an accepted method of treatment for difficulties in the early years. The Tavistock’s model involved families being offered five parent-child psychotherapy sessions, with the possibility of an additional five sessions, if required (Emanuel, 2011). The focus was on providing a brief, prompt and flexible therapeutic approach (Emanuel and Bradley, 2008) and it was upon this brief, five-session, model of intervention that my project was based.

We know that children can arouse all sorts of infantile feelings in their parents and it can be that unresolved experiences in the parents’ own lives can have a detrimental impact not only on their own attachments, but on their attachment to their child and, thus, the child’s development. By working with the child and parent(s) together, it is hoped that thinking can be done about both the child’s presenting difficulty and the parent-child relationship.

The five session model can help both clinicians and families focus on the key issues within the child and/or family and this can be helpful not only with regard to the current difficulty, but also on transgenerational and longer term challenges within the family (Emanuel and Bradley, 2008).

The Anna Freud Centre also provides a service to parents and their young children, known as the ‘Parent Infant Project’ (or PIP). The service works with parents and their infants, and the aim of the psychotherapeutic work is to put, ‘*the relationship between parent and baby at its centre, acknowledging the need to understand and to make sense of the impact that the baby has on the parent and vice-versa’* (Parent Infant Project, 2019).

Baradon and colleagues (2005) described the work at the Anna Freud centre, explaining that several different forms of treatment can be offered by the service, including individual family work, brief therapeutic intervention, group work and crisis support.

Steele and Baradon (2004) explored how the Adult Attachment Interview (AAI) is used within work offered by the PIP. They found that the AAI can be a useful tool to discover information about the parents’ experiences in childhood, which can be helpful in exploring and addressing the current relationship between the parent and their child. This is clearly a more structured way of gathering information about the parents’ history than is done in other types of parent-infant work, but the end goal is the same – trying to keep both the child’s presenting difficulties and the parents’ experiences and history within the frame of focus, recognising how both are interlinked and can be helpfully addressed in tandem.

There are also organisations and charities, whose focus is infant mental health and whose aim is to provide support for families and practitioners. For example, The Parent Infant Partnership has set up hubs across the United Kingdom, providing infant mental health provisions, including therapeutic work for infants and parents. The Association of Infant Mental Health (AIMH) is a charity which aims to provide support for infant mental health, including training and education for professionals; and The Parent and Infant Relationships Service (PAIRS) is a London based provision which offers support for parents of children under the age of four years old.

There are a variety of parent-child psychotherapy models, which are based on similar principles; however, their individual delivery varies. Some, for example, like the Tavistock Under-Fives service, offer a set number of sessions, whereas others have been more opened ended in the duration of the treatment, offering different families different numbers of sessions depending on need (Cicchetti, 1999). Rustin and Emanuel (2010) referred to three kinds of work supporting parents and young children; parent consultation; parent-child therapy; and professional consultation. There are, therefore, distinctions between the focus of the work and this may depend on various factors, including the relationship between the parent-child, the availability (either physically or emotionally) of the parent and the willingness and engagement of professionals.

Some models have involved the sessions being video recorded (Jones, 2012; Onions, 2009). Jones (2012) described how the video camera provides an '*entry point'* (p. 303) for the parents, allowing them to watch and notice something about their child and their interactions together. Furthermore, Lieberman (2004[b]) referred to a manual which she and a colleague had worked on, providing guidelines for parent-child psychotherapy.

Balbernie (1998) conducted a review of some of the methods of intervention for parents and infants in America. These models were not all psychoanalytically informed and included ‘Watch, Wait and Wonder’, ‘Interactional Guidance’ and ‘Infant Parent Psychotherapy’. Balbernie introduced what I felt to be a very helpful idea, suggesting that in parent-infant work the relationship is the ‘*patient*’ (p. 19). He differentiated parent-infant psychotherapy from some of the other methods of working by highlighting how it involves focusing on the parental experiences and how these may be re-enacted, with negative consequences, in the current parent-child relationship.

It was reading about some of these existing models of working and provisions which initially caught my interest and planted the seed from which my research project grew. I decided that I could make use of one of these pre-existing and successful models, in the form of a pilot project. The aim of my project was not to invent something novel, but rather introduce a pre-existing model into a team which did not routinely offer this service and see how it was received.

I decided that a brief model of working might be helpful, as it seemed from the literature that there is a great scope for change in both young children and their parents. I also felt that this brief model would fit well within the current political climate within the NHS, in which effective, short-term work is often a well-received therapeutic approach (Rustin and Emanuel, 2010).

In Government Policy, there have been several important publications in the last few years which have referred directly to work with infants, young children and families, and are relevant when considering the importance of infant mental health and service development. The *Future in Mind* document (Department of Health, 2015) advised that greater support be offered within the fields of maternal, perinatal and early years’ health and wellbeing. The paper highlighted the link between parental mental health difficulties and mental health difficulties within children, and a focus is put on expanding perinatal services and offering evidence based programmes, in order to support the attachment between children and their parents after birth.

In 2017, the *Transforming Children and Young People's Mental Health Provision* Green Paper was published (Department of Health and Social care and Department of Education). In this paper, there was the frequent mention of 'early intervention' and references made to early brain development, perinatal provisions and pregnancy. Whilst reference was made to increasing provisions within schools, colleges and universities, curiously there was no specific mention of nurseries or work with under-fives.

The *1001 Days* cross-party manifesto (Leadsom et al, no date) puts forward a drive for better services and provisions for infants from conception to two years old, and their parents. A tiered approach to parent-infant work is given, identifying four levels of intervention: Tier 1 which is universal support; Tier 2 which is additional clinical and universal support for families in need; Tier 3 which is specialist services where difficulties and a high level of need is apparent; and Tier 4 which refers to families where there are severe mental health problems which require psychiatric involvement. According to this model, my intervention would fall within Tier 3, but it might also be possible to make use of parent-child therapy, in cases without high levels of complexity, within Tier 2. The *1001 Days* project shines a spotlight on the importance of the first two years of a baby's life, and calls for multi-agency joint working to ensure the best possible outcomes for baby and their parents.

The three publications referred to above all made it very clear that young children cannot be seen in isolation, but instead services need to target parents as well. These documents sit within a wider context, in which the importance of supporting children's mental health (including that of babies and young children) is being highlighted at Government level.

I also want to draw attention to the recommendations given in the National Institute for Health and Care Excellence (NICE) guidelines, particularly those relating to Children's Attachment (NG26; NICE, 2020) and Child Abuse and Neglect (NG76; NICE, 2020). Interestingly, parent-child psychotherapy is referred to directly in terms of families where the child either has experienced, or is at risk of experiencing maltreatment by their families. It could be said that such families already have complex relational difficulties and it is important to note that the guidelines specify that this parent-child therapy must last for at least one year. This does, therefore, differ from the kind of early intervention which is often associated to short-term parent-child psychotherapy, as used in my pilot.

I shall now provide an overview of what the intervention looked like, and how it will be presented within this thesis.

iv. The project

The project involved offering a small number of families a brief therapeutic intervention, involving five parent-child psychotherapy sessions, working within a psychoanalytically informed framework. Each family was offered a pre and post treatment interview and outcome measures were used to support the qualitative data gathered from the therapy sessions themselves.

The pilot took place within a CAMHS clinic within the South of England. As previously mentioned, this kind of parent-child work did not routinely take place within this specific service, or within the geographical area more widely. I want to make brief reference here to the clinical pathways that were used within the Trust, one of which was the

‘Attachment Pathway’. These pathways were used to inform decision making about treatments and interventions, depending on the presenting difficulties. It is worth noting that according to this pathway, at the time this project took place, the recommended intervention for pre-school children with attachment difficulties was 10 Video Interactive Guidance (VIG) sessions, whilst for school age children the recommendation was 5-15 Parent Sensitivity Behavioural Training sessions.

I mention this because, at the time the project was being planned and carried out, the team did not have any staff members who were trained in either of these models of intervention, so we were, therefore, not able to fully meet the pathway’s recommendations. I understand that these recommendations were informed by the NICE guidelines (NG26 and NG76, 2020); however, unfortunately, they did not accurately reflect the resources available in the team at the time and, therefore, they could not fully meet the needs of the client group.

The pathway did also state that if problems persisted after these interventions and there were concerns about the child being at risk of maltreatment, then parent-child psychotherapy in the home, for over 12 months, was recommended. This is interesting, because it is clear that parent-child psychotherapy was only being recommended when other interventions had not worked and there were significant safeguarding concerns. It is also significant that the Pathway outlined that this intervention had to take place for over a year, so it was, therefore, a very different intervention to that being offered within my project.

The CAMHS clinic in which the project took place is located in quite a deprived area, in which there are high rates of unemployment, drug misuse and financial difficulties. The clinic is commissioned to work with 0-18 year olds; however, the young age group is under-represented within our referral intake. The team itself is made up of nurses, psychologists, psychiatrists, crisis workers, primary mental health workers and psychotherapists. It is a fairly large team, with about 30 members of staff.

I recruited five families in total with children aged from three to five years old. The project was open to children of any age (under five), but during the recruitment period, no child below the age of three was referred into the clinic. The children were referred for a variety of reasons, including concerns about high levels of aggression, the presence of regressed behaviour, or issues regarding the child's relationship with their siblings or parents. The children came from a range of different family make ups, including a single parent family, an adopted child and a looked after child. All of the children had siblings, although not all of the siblings attended the sessions. The families came from a range of socio-economic backgrounds and at the point of referral the families had varying experiences of CAMHS, as well as other services. I will provide a more detailed introduction to each of the families in the methodology section.

v. The outline of this thesis

In this thesis, I will begin with a literature review, exploring the relevant theory and texts associated to parent-infant (or parent-child) psychotherapy and infant mental health. I will give a summary of the key literature which helped inform and develop my work, as well as trying to provide an overview of literature within this field more generally. I will then go on to explore the methodology used within this project, including the methods of data collection and analysis, the sample, inclusion and exclusion criteria and thoughts about psychoanalytic research in general. Following this, I will present my findings. My findings are going to be presented in two separate chapters; the first will address the clinical data derived from my therapeutic intervention, whilst the second will explore the data gathered from the outcome measures employed within the project – semi-structured interviews, goal-based outcomes and an Experience of Service questionnaire, as well as information gathered from my presentations to the clinic team. Finally, I will present my conclusions from the project as a whole, bringing together the two findings chapters and some thoughts about the potential implications of the project for future research and service development. I will end with a postscript chapter, giving a brief summary of what happened to each of the families following their involvement in the project.

All names and identifiable details have been changed, as far as possible, in order to ensure anonymity and confidentiality. The families all gave consent to be part of this project and part of that consent was for their data to be written up for the purpose of publication within this thesis. Any reference to the clinic name or geographical area have also been removed, in order to further protect the participants' anonymity.

Literature Review

In order to discover the relevant literature in this field, I made use of journal and book searches. Whilst some of the titles and authors were familiar to me, I also wanted to expand my knowledge and find additional literature. Searches were conducted across various databases, included PsychInfo, ResearchGate, EbscoHost, Pep-web Archive and The Tavistock and Portman Library webpage.

I used various search terms when trying to find relevant literature, which initially centred around, ‘brief psychotherapy’, ‘work with under-fives’, ‘parent-infant psychotherapy’ and ‘parent-child psychotherapy’. When looking into the outcomes of such work, I used search terms including ‘levels of change in parent-infant/child psychotherapy’ and ‘outcomes in parent-infant/child work’. Terms such as ‘infant observation’, ‘child development’ and ‘the parent-child relationship’ were also used throughout this literature review.

Relevant journal titles included ‘Journal of Child Psychotherapy’, ‘Child Development’, ‘Journal of Clinical Psychoanalysis’, ‘Infant Mental Health Journal’, ‘International Journal of Psychoanalysis’ and ‘Infant Observation’.

I discovered a vast and diverse range of relevant literature, so in order to try to summarise this literature, I have separated it into five sections. The first provides an overview of the early thoughts about the parent-child relationship drawing on contributions from Freud, Klein and Bion, amongst others. The second section explores some of the literature which has informed our understanding of children and how we can learn about their communication and development. The third addresses the literature focusing on therapeutic ways of working with parents and their children together and the fourth provides a summary of how this work has looked in practice. Finally, I explored the literature focusing on the outcomes of parent-child psychotherapy.

Two books proved to be particularly valuable during this literature review and my project in general; these were, *“What can the matter be?”: Therapeutic interventions with parents, infants and young children,* edited by Emanuel and Bradley (2008) and *Innovations in parent-infant psychotherapy,* edited by Pozzi-Monzo and Tydeman (2007). The chapters in these books were not only informative in their own right, but they also directed me to other interesting and helpful texts and authors.

It is important to note that the following literature includes reference to both parent-infant and parent-child work. As I began my searches, I reached the view that, although these types of work are different, there are clearly overlaps and similarities between them. Out of interest, I tried to find a definition of infancy, to order ascertain whether there was such a thing – a specific age range, or a time when an individual moves from being an ‘infant’ to a ‘child’. The Cambridge Dictionary (2019) defined an infant as ‘*a baby or very young child’*, which seems consistent with other dictionary definitions. The Cambridge Dictionary also referred to Infant School, for children aged four to seven years old. If we consider this definition, then perhaps infancy includes babies all the way up to young children.

When I searched within relevant journal articles, there was not a great amount written in terms of the definition of infancy, although the word is used frequently. Some researchers, such as Fonagy and Sleed (2016) defined ‘infancy’ as under twelve months old whilst others extended this to twenty-four months (Barlow et al, 2016). Interestingly, in the preface to ‘What can the matter be?’ (Emanuel and Bradley, 2008), it is suggested that, in the book’s chapters, the word infancy is used to mean children under the age of five years old, therefore, giving quite a broad meaning to the word. However, the authors also go on to highlight how even within this age range, different approaches will be needed.

Perhaps we could find ourselves engaged in a discussion of semantics, although it does seem important to highlight the differences in the way in which the word infancy is used. During my project, I set out to recruit children ‘under the age of five’, which could have included infants from birth. In reality, I only recruited children who were four (or just turning four) or five years old, as these were the cases referred to the clinic during the time-frame. I believe that, within the context of the above distinctions, the participants recruited would be classified as young children, rather than infants, per se.

A differentiation between brief work with infants and young children was not always clear in the literature, and I found contributions regarding psychotherapeutic intervention with all young children helpful in the development of the project and in my thinking during the clinical interventions and the writing up.

Interestingly, Lieberman (2004[b]) did make a clear distinction between parent-infant and parent-child psychotherapy, although this was in reference to longer term work, rather than brief interventions specifically. Lieberman suggested that in the parent-child psychotherapy there is an increased focus on creating a mutual meaning between parent(s) and child, and less focus on the child’s developing sense of agency and the parents’ own childhood experiences. The relevance of this distinction became more evident for me as my project, and the clinical work, developed.

That said, for the purposes of this literature review, and the write-up in general, I decided to use the terms parent-infant and parent-child interchangeably, except on the few occasions when it was important to draw a distinction. I will make reference to parent-child psychotherapy, as a more general term, especially in relation to the historical contributions and the thinking behind involving both the child and their parent(s). However, my primary focus, in terms of models of intervention, will be on literature relating to brief methods of working with children and parents, and it is the ways in which psychoanalytic principles can be applied to this model of short-term work which I have explored in detail.

Whilst I have tried to include an over-view of the most salient and informative literature within this field, certain topics have had to be excluded because of space limitations. I will make reference to different approaches to parent-child psychotherapy, focusing mainly on brief interventions. However, I have been unable to provide an exploration of some of the alternative ways of working, such as individual psychotherapy for under-fives. Offering therapeutic intervention for the child individually is an established way of working, and it is an essential part of psychotherapy training. However, I felt that it would be most relevant to focus this review on the theory, processes and findings from work with parents and children together.

I have also provided a brief summary of some of the literature on child development and neuroscience; but this is certainly a whistle-stop tour of these areas, rather than a full exploration, as a full overview would have been beyond the remit of this literature review.

i. Early thoughts on the parent-child relationship

Freud (1926), in discussion regarding the root of difficulties in adulthood, highlighted the importance of the individual's childhood and relationship with his or her parent(s). Freud emphasised the importance that these early relationships and bonds play on the child's later development and wellbeing. Freud's idea became a core belief within psychoanalytic psychotherapy; that many difficulties in adulthood have their roots in childhood, linking to the early parent-child relationships.

Klein's approach to children built and expanded upon Freud's ideas. In 1957, Klein suggested, '*It is inherent in Freud's discoveries that the exploration of the patient's past, of his childhood, and of his unconscious is a precondition for understanding his adult personality'* (no page). She went on to suggest that children, from birth, have experiences, phantasies, desires and wishes, which she believed could be worked with directly in child-analysis (Klein, 1988). Whilst Klein's approach involved working with the child individually, she contributed to our understanding of the parent-child relationship. Klein (1936) said:

> *The mother must realize that the baby is not actually her possession, and that, though he is so small and utterly dependent on her help, he is a separate entity and out to be treated as an individual human being; she must not tie him too much to herself, but assist him to grow up to independence* (p. 300)

Klein was highlighting the importance of the mother in terms of the baby's survival and connection with the world, but also noting how babies will have their own experiences and thoughts, separate to those of their mothers (or parents). Klein was drawing our attention to the risk of the parent 'tying' the baby up too closely to them, therefore, not allowing separation or individuality. Growing up and developing is a process of separation, and parents must help their children to prepare for and tolerate this parting. It could be suggested that this links not only to the physical aspects of togetherness and separation but also the psychological aspects, whereby children must not be too put upon by their parents' experiences, views or memories, as this would hinder their own development and wellbeing.

Klein (1946) described how the infant begins life in what was referred to as a 'paranoid position'. This position develops in response to the high levels of anxiety and frustration, as well as fears of annihilation, which the child experiences in their early years, and which they must find a way of managing. The child, during the paranoid-schizoid position, will project these unwanted and intolerable feelings into their object (i.e. the breast, or their mother) as a way of getting rid of the experience. Klein described how initially the child will make use of a process of splitting, projecting different feelings into the mother (or parent), including unwanted or difficult feelings or experience, as well as good or positive feelings – this was referred to as 'projective identification' (Klein, 1952).

What is central to this stage is that the 'good' and the 'bad' are experienced by the infant as separate and disconnected parts. The difficult and painful experiences which are projected into the 'bad breast' (or 'bad mother') are perceived as being separate from those good experiences, associated with the 'good breast' (or 'good mother'). If the parent can take in these projections and help the child to 'digest' them, then, over time, the child will begin to see the good and the bad as part of one whole, a process of integration will occur, where by *'The loved and hated aspects of the mother are no longer felt to be so widely separated'* (Klein, 1946, no page). Klein (1946) referred to this as a movement into the 'depressive position'.

Whilst Klein suggested this transition into the depressive position marked a process of development; within this new position, the child goes on to experience different challenging and difficult feelings, associated with the integration of good and part parts of the object. Klein described how, *‘the result is an increased fear of loss, a strong feeling of guilt and states akin to mourning, because the aggressive impulses are felt to be directed against the loved* object’ (1946: no page). The process of integration brings with it both relief but also new experiences of discomfort.

Central to psychoanalytic thinking is the notion that these experiences of frustration and hatred, as well as the projection or splitting off of these feelings happen unconsciously. It has been described how the young child will experience feelings at an unconscious or semi-conscious level and this, paired with the fact that the child may be non-verbal or have limited use of language, can make it difficult for the child to express itself, and for parents to understand of make sense of the child’s communications (Klein, 1928). The psychoanalytic therapist, whether working with children or adults (or both together) will, therefore, make use of his or her counter-transference, in order to help them to notice and respond to the unconscious communications within the therapy sessions. I will say more about this further on within this review.

The movement between the paranoid-schizoid and depressive positions is not limited to infancy, and it has been said that the experience of depressive states is an ‘*inevitable part of the human condition’* (Likierman, 2001: 105). Likierman (2001) went on to explain that adult patients can demonstrate times when ‘*sadism prevails’* and other times when ‘*love prevails’* (p. 106), in a similar way to that which can be seen with infants and young children. When working with parents and children together, we must, therefore, be mindful of these positions or states which can be present in both the child and their parent(s).

Klein (1957) suggested that the young child needs a parent who can respond consistently and will help the child to process and digest feelings of distress, upset, and anger. Whilst Klein referred to the mother-infant relationship predominantly, I believe it is appropriate to extend this to the parent-infant relationship more broadly. A baby will need to develop an ability to tolerate feelings of anxiety and discomfort, and parents play a central part in developing this tolerance. Difficulties can arise, however, if the baby experiences particularly high and persistent levels of anxiety which are intolerable, or if the parent is unable to help their child to contain and process these anxieties (Rustin and Rustin, 2017). Watillon-Naveau (2010) suggested that '*An event only becomes traumatic if it cannot be processed and integrated'* (p. 32) and we may understand this inability to process or integrate an event in relation to the two factors highlighted by Rustin and Rustin (2017) – the child's individual constitution and the parental availability.

If the child has an experience of reliable and dependable caregivers, who are emotionally available and responsive, then the child will, in time, develop an internal object themselves capable of love, development and reparation.

Winnicott (1951) referred to the idea of 'good enough' mothering, suggesting:

> *The good-enough mother, as I have stated, starts off with an almost complete adaptation to her infant's needs, and as time proceeds she adapts less and less completely, gradually, according to the infant's growing ability to deal with her failure* (p. 238)

This concept describes how parents may need, initially, to be completely available and responsive to their children, however, as babies develop, they will over time be able to tolerate separation and disappointment, if they have had the experience of ‘good enough’ parenting and responsiveness initially.

Bion (1962) used the terms ‘container’ and ‘contained’ to explore the early mother-child relationship, building upon Klein’s theory of projective identification. Bion stated, *‘the idea of a container into which an object is projected and the object that can be projected into the container: the latter I shall designate by the term contained’*. (1962: 90). In terms of the mother and the child, the child could project his or her more difficult or uncomfortable feelings into the mother (the container) who could help the baby to process or make sense of these experiences, thus helping the child to feel contained.

In 1967, Bion went on to explain more about his concept of containment:

> *Normal development follows if the relationship between infant and breast permits the infant to project a feeling, say, that it is dying into the mother and to reintroject it after its sojourn in the breast has made it tolerable to the infant psyche. If the projection is not accepted by the mother the infant feels that its feeling that it is dying is stripped of such meaning as it has. It therefore reintrojects, not a fear of dying made tolerable, but a nameless dread.* (p.116)

We see, therefore, that if the mother is not available to take-in these projections from their child, and help them process them, then the original feelings or communications can become exacerbated or more challenging to cope with (such as Bion’s idea of ‘nameless dread’). Britton (1991) in his exploration of Bion’s concept of container-contained referred to the way in which the mother must help to contain and process some of her child’s experiences and communications:

> *The mother, if she was receptive to the infant's state of mind and capable of allowing it to be evoked in herself, could process it in such a way that in an identifiable form she could attend to it in the infant* (p. 105)

Interestingly, Britton also referred to how the father can help to contain some of the mother's anxieties, which leaves her more able to respond to and be available for the child. We can see the importance of this concept of 'containment' and, we may extend this to thinking about how the therapist can contain both the parents' and child's projections, in order to help make them more manageable and bearable (Bion, 1967).

This brings to mind Britton's (1989) writing about triadic relationships, and the child's experience of being the third. Britton suggested:

> *If the link between the parents perceived in love and hate can be tolerated in the child's mind, it provides him with a prototype for an object relationship of a third kind in which he is a witness and not a participant* (p. 87)

This links to both Klein's theories of part and whole object relations and, I believe, the task of parent-child therapy, which often involves three individuals – parent, child and therapist. The way in which the child can manage and tolerate this experience of a triadic relationship can give an insight into how the child has experienced being with their parents (if both parents are present) and being 'the third'. Through the therapy, the child will have the experience of adults coming together helpfully.

Whilst Klein contributed greatly to our understanding of children and child analysis, and stated clearly the link between a child's early experiences and relationship with his or her parent(s) to its later development, she did not, however, directly include parents within the analysis of children. Sherwin-White (2017[a]), in her book *Melanie Klein Revisited*, made reference to Klein's writing which directly addressed the ways she believed parents should and should not be involved in child analysis. Klein believed that, whilst on a conscious level parents may be supportive of their child's therapy, there can be '*unconscious ambivalence and opposition*' (Sherwin-White, 2017[a]: 208) which can disrupt therapy, if not carefully managed. Whilst Klein did not find it helpful to allow parents to join their child's sessions, she did offer some contact to parents outside the sessions, in the form of meetings, written correspondence and by telephone (Sherwin-White, 2017[a]). It is interesting to note that both the child's therapy and the liaison with parents were both offered by Klein herself, rather than a colleague being found to offer the parent sessions, in the way that we are perhaps more familiar with today.

Rustin and Rustin (2017) also made reference to this, explaining that this is one area which has developed and changed quite considerably since Klein's time, and now parents are widely offered 'parent-work', to support their child's therapy or, as in this project, the child and its parent(s) can also be worked with together. It seems that Klein was not trying to build a therapeutic relationship with parents as such, in the way we often see today. Instead, as Sherwin-White (2017[a]) suggested, Klein's involvement with parents was limited to gaining consent, ensuring the child's appointments were attended and giving limited feedback on the progress of the therapy, whilst ensuring that the child's confidentiality was upheld.

I have, in this section, aimed to provide an over-view of the foundations of theory focusing on the early parent-child relationship, and its impact on later development and functioning. These early contributions form what could be described as the basis for parent-child work as we know it now, acknowledging the importance of various factors within the parent-child relationship. These include the way in which the parent(s) can help their child to manage and tolerate experiences, how the child receives their parent(s) and how experiences in infancy can have an impact in adulthood. I will now go on to explore some of the literature which has built upon these early contributions, focusing on the children and the way we can learn about infants' communication and development.

ii. Understanding children

This section of the literature review is separated into two sub-sections. I shall begin by looking at Infant Observation, and its uses within training and clinical work; I will then refer to some theories on child development more generally, including some contributions from the field of neuroscience.

Infant observation

In 1916, Freud referred to the importance of the observation of children and how early inferences from adult analysis were later supported by direct observation of children. Sherwin-White (2017[b]) referred to how, although not largely written about, Klein also made use of the observation of young children in her clinical work, including '*the quality and character of their [the child's] non-verbal communications, facial expressions, and body language'* (p. 23). Klein highlighted how we must consider the child's internal world and their ability to communicate with others, starting from the very earliest stages of development; observation can be a helpful tool in aiding our understanding of this (Sherwin-White, 2017[b]).

This recognition of the importance of the observation of children (from infancy) has continued to develop over time, and in 1948, infant observation was made a core part of training for Child and Adolescent Psychotherapists at the Tavistock Clinic (Shuttleworth, 1989).

Esther Bick (1964), who was responsible for the development of the use of infant observation within psychotherapy training, described how infant observation involved students visiting a family once a week, for an hour, for the first two years of a baby's life. Notes are recorded by the student afterwards, and these go on to form the basis of seminar discussions and essays. When carrying out an observation, the student's 'job' is to observe, notice and be attentive (Rustin, 1989[1]), rather than offer any clinical intervention. Michael Rustin explained, in relation to the students, *'They are meant to learn the capacity to observe, reflect, and mentally process their emotional experience (and the contained management of themselves whilst this is all going on), before they learn how to intervene as clinicians'* (1997:96).

Infant observation does, therefore, form the basis of psychotherapy training, and, whilst it is a useful task in itself, it continues to be a tool we make use of throughout our clinical work, pre and post qualification. However, whilst during infant observation, the role of the observer is to do just that, observe; when we make use of observation in clinical work we often try to find ways of feeding back our observations, helping the child (or child and parents) to notice things and think together about what they might mean. Besides the use of observation in clinical work, it also contributes to the development of theory (Bowlby, 1969; Briggs, 1997), as well as being used increasingly within research (Rustin, 1989[2], 1997; Rhode, 2004).

Miller (1992) compared the role of observer (during an infant observation) and the role of the therapist when meeting a family for parent-infant work. Miller described how both observer and clinician must attempt to be, ‘*interested, friendly but at the same time neither intrusive nor intimate’* (p. 21).

Elizabeth Bradley (2008) titled a section of one of her papers, '*The effect of perinatal loss: observation as an intervention’*. Bradley referred, in brief, to a piece of parent-child work she carried out, describing how she observed and noticed both the parent’s and children’s communications during the session. These observations were shared with the family, which allowed the family members to see things from others’ points of view, thus helping to shift and un-stick the current difficulties. There are many more examples of clinical work in which the therapist has made use of observation as a key part of their intervention with the family (Fraiberg et al, 1975; Cicchetti, 1999; Gurion, 2008 and Gretton, 2006).

Shulman (2016) has explored the way in which infant observation can be an invaluable tool when conducting parent-infant work with mothers with severe mental health difficulties. The work described in the paper took place within the home, as many of the parents were too unwell to travel to a clinic. This approach of working within the home closely mirrors how infant observation during psychotherapy training is done, and perhaps this naturalistic home environment is particularly important if we are trying to observe the parent-child relationship in its truest form. The clinical example included detailed notes of both the interactions between parent and therapist, and also, and perhaps most importantly, observation made of the child and the way in which he interacted with his mother. Below is an excerpt from one of the clinical vignettes given:

> *Mother spoke to him affectionately again – Euan again gave no response – and she then turned him on her lap so he was facing the other way across her lap; Euan now rested his hand lightly on mother’s hand, and looked straight ahead*

> *into space i.e. beyond the end of the couch, keeping his head in a fixed position* (p. 104)

The level of detail observed by the therapist is clear, including the movements of the face and the focus of the eyes. By recording the minutiae we can begin to create a very detailed picture of the relationship – both physically and psychologically – between the child and their parent. It could be said that this level of observation is more challenging when working with an older and more active child, as well as two parents. This is, perhaps, where having a co-therapist could be helpful, in order to provide a second person to observe, notice and respond to the family and what is happening during the session.

An important part of parent-child work is attending to the communications of both the parent and the child. If the child is non-verbal then observation is even more crucial, as the baby will communicate his or her experiences through their movements, noises and play, so the therapist must be attuned to and focused on these, as well as what is directly spoken about by the parent (Watillon-Naveau, 1999).

The task of observing young children (as opposed to babies) can be somewhat more challenging, due to the child being more mobile, more vocal and more active and independent. Observers can find themselves struggling with matters that do not have such prominence when observing a baby, such as with the maintaining of boundaries (for example, whether to join in with the child's play, or not) and issues relating to privacy, intrusion and space (Henry, 2014). Despite these challenges, it has been said that, '*Young Child Observation, more than Infant Observation, gives us the opportunity to get to know the social world the child inhabits. It holds a mirror to the social relations of the child and a window into family relationships*' (Fagan, 2014: 84). The social relations Fagan referred to could include the way the child relates to its parents (if the observations take place at home); to peers and staff (if the child is observed in nursery) and to us, as both visitors and observers. This can be helpful, whether our observation is for the purpose of observation alone (such as during a training programme), or whether it forms part of a clinical intervention, or, indeed as research.

Interestingly, it is important to note, that whilst the UK (and perhaps other countries too) puts an emphasis on the use of infant observational skills during parent-infant work, this is not the case across the board. In Norway, for example, therapists are not trained in, and therefore do not make use of, observational skills within their work, opting instead for more standardized or structured tools (Osafo, 2006). There have also been discussions around the compatibility of infant observations with psychoanalytic principles. Green (2000), for example, referred to unconscious processes and communications being the primary focus within psychoanalysis (or psychotherapy) rather than the ‘real’, observable child. I do not, however, think that the two are mutually exclusive. In the same way that psychotherapy is aided by an understanding of projections and transference, as well as a robust understanding of child development and neuroscience (which I say more about shortly), we must find ways of working with both the past and present and the conscious and the unconscious. Furthermore, we can use our observational skills to observe both the patient, as well as our own counter-transference.

In summary, infant observation is a core part of a child psychotherapist’s training in the UK; however, it also goes on to be a tool used during later clinical work, including during brief work, where the therapist must draw upon all forms of communication in order to gain as much information and understanding as possible in the time available.

I will now say a little about child development and some of the literature which is particularly salient when considering parent-child psychotherapy and the development of young children.

A few thoughts about child development

It is beyond the scope of this literature review to provide a full summary of the literature on child development. However, I wanted to include this as a sub-heading in order to try and capture something of the different views on child development, in particular in relation to the role that parents/carers play, and to make reference to some of the contributions from a neuroscience perspective.

Back in 1940, Melanie Klein stated, *'Unpleasant experiences and the lack of enjoyable ones, in the young child, especially lack of happy and close contact with loved people, increase ambivalence, diminish trust and hope and confirm anxieties about inner annihilation and external persecution'* (p. 347).

Klein was highlighting how the experience of negative interactions or the lack of positive relationships in infancy can have a negative impact on the way in which the child develops socially and emotionally. Subsequently, many people have written more explicitly about this link.

Different theories of child development put emphasis on different influences or factors. For example, Bowlby's attachment theory (1969) identified the infant's early social interactions with their caregiver as the foundation for their 'attachment style' in all of their on-going relationships. Bronfenbrenner's (1979) 'ecological model' of development also identified the child's relationship with their parents as being at the core of child development, however, this was in the context of other factors too, such as the family's financial situation, and the wider political or social influences.

Whilst not all theories of child development give such attention to the very early parent-child relationship, in psychotherapy we believe that these early experiences have long-term consequences.

Many researchers have set out to explore child development, in the context of parental functioning and communication, for example, Sorce and colleague’s (1985) work which found that twelve month old babies use their mother’s expressions to assess risk; and Feldman’s (2004) research which demonstrated how infants that received kangaroo-care (meaning skin-to-skin contact) showed better emotional regulation, executive functioning and impulse control at five years old. These studies highlight what we perhaps might instinctively already know – that the infant relies solely on their parents in order to feel safe, to grow and to develop. The parental containment and support, both physically and emotionally, allows the child to explore, gain independence and proceed with healthy development.

There are, however, times when the parents, for different reasons, are less able to offer this support to their child. Poor parental mental health can have a significant impact on a child’s physical and emotional development, starting in utero. Foetal activity, for example, was found to be higher in foetuses of depressed mothers (Dieter et al, 2001), and babies that were more active as foetus’ were found to be more unpredictable, active and challenging in infancy, and to show less ‘emotional tone’ (DiPietro et al, 1996). It has also been found that children of mothers with a border line personality disorder go on to be less able in social tasks and they also make less use of the adults around them when trying to complete tasks (Hobson, 2002). Such research is important when considering the kinds of referrals received in CAMHS teams and how, for many of these cases, there are underlying parental mental health problems present too. These difficulties are not always evident at the time of referral and sometimes only emerge further down the line.

Perhaps it is unsurprising that much of the research into child development focuses on the role of the mother; however, it is important that we do not underestimate the role of the father in the child's development, especially when we are considering factors such as parental mental health. I will go on to address how fathers can be actively involved within parent-child work later on within this review.

The field of neuroscience has added another level of detail to our understanding of child development, particularly in relation to the early brain development and the factors affecting this. Psychotherapists have always paid close attention to early development and experiences and it is interesting to consider this in relation to all areas of growth, including within the brain. This is, of course, very relevant when we are considering parent-infant work because the children involved will often be of an age during which significant development (brain, physical and emotional) is occurring. Balbernie (2001: 247) stated, '*The recent advances in neuroscience back up the emphasis in psychoanalytic theory on the significance of early experiences for later development'.* There are clear overlaps between the aims of psychoanalytically informed therapeutic work and evidence from research into brain development.

Gerhardt (2004) talked about the impact that internal suffering in the parents has on the child in terms of the attachment between the two, but also, the brain development in the child. She explained how the quality of parent-infant interactions will affect how the baby's orbitofrontal cortex (associated with management of emotions) develops.

Music (2019) explained that the prefrontal cortex (in which the orbitofrontal cortex is located) is linked with tasks such as '*inhibiting impulsiveness, executive planning,* *empathy and interpersonal skills'* (p. 59). If this area of the brain is underdeveloped, then we may see children who struggle with their self-regulation and self-control and for whom managing relationships and communicating feelings is a challenge. Interestingly, Music (2019) also highlighted how if an infant has the experience of stress during pregnancy, or a mother in psychological distress, they can cut themselves off from the experience of stress, and instead express themselves through their body, such as through aggression or violence, or sexualised behaviours. Again, this is important when we consider how often referrals to CAMHS teams (especially, in my experience, those for younger children) make reference to high levels of physical expression, aggression and anger.

We know that having the experience of being thought about and understood by others, in infancy, will also aid later development of self-reflection and interpersonal capabilities (Music, 2011). On the other hand, if a baby's signals and communications are repeatedly not responded to by their carers then '*momentary coping mechanisms turn into ongoing patterns, leading to giving up on even kindly empathetic adults'* (Music, 2019:31). We can, therefore, see how children can develop ways of responding, based on expectation and previous experiences with their parents/carers.

Pozzi and Tydeman (2005) noted that '*Plasticity is an aspect of both the early years and early parenthood. Symptoms and patterns of behaviour are not yet fixed in infancy and can be rectified easily'* (no page). Young children indicate levels of change which can occur quickly (Gerhardt, 2004) and so, if an early intervention can be offered, it is likely to reduce long lasting or deep-rooted difficulties. Hopkins (2008) suggested that within the first two and a half years of a child's life patterns have not become fixed and there remains '*a remarkable behavioural flexibility'* (p. 65)

This literature captures the interrelated nature of the children's development with their relationship with their parents, and their parents' mental functioning. This again highlights the dual focus of parent-child work, whereby the therapist must attend to the child but also the parent(s), in order to help the parents to get in touch with and connect with their child's communications and the factors which might be influencing the current situation.

Brief parent-child work involves working with young children and the ultimate aim is to try to alleviate some of the difficulties experienced by the child or the family, in order to aid future development, growth and health. It is vital that psychotherapists have a good understanding of 'typical' child development, in order to help identify and respond to cases where the child's development may not be progressing along the usual or expected trajectory.

I shall now focus, in more detail, on the task of working therapeutically with the child and the parent(s) together, and some of the factors and considerations which will link to this.

iii. Working with the child and the parent(s)

The child in context – the focus of the work

It could be suggested that at the heart of parent-infant or parent-child work is the belief, as Winnicott suggested, '*There is no such thing as an infant'* (1960:586), meaning we cannot view the infant in isolation, but instead within the context of the parent-child dyad (or triad). Hopkins echoed this idea in her paper on parent-infant psychotherapy, when she said that there is '*no such thing as individual psychopathology in infancy'* (1992:5). It seems that both of these statements were highlighting the importance of the relationship between the child and their parent(s) and how, in order to address difficulties in young children we must consider the child within the context of the parent-child relationship and the impact of the parents’ experiences and functioning on the child.

It has been said that Selma Fraiberg was responsible for first developing parent-infant psychotherapy (Hopkins, 2008). Certainly a seminal contribution to this area was Fraiberg et al’s 1975 paper ‘Ghosts in the nursery’. This paper clearly captured how elements of the parents’ pasts can resurface when a child is born, which has an impact on both the parent-child relationship and parental functioning. It was suggested that, ‘*intruders from the parental past may break through the magic circle in an unguarded moment’* (1975: 387) which conveys how quickly and powerfully these ‘ghosts’ can reappear and take hold of the current situation. Later, they referred to the ‘*ghost story’* which is an interesting idea – perhaps one of the aims of parent-child work is to try and put the story into words, finding a way of capturing something, which may have been previously untold.

Juliet Hopkins (2008) explored the significance of Fraiberg’s contributions, noting how Fraiberg’s model combined interpretative work with ‘developmental guidance’. Hopkins described how Fraiberg’s contributions in the 1970s and 1980s remain very relevant today and have been at the heart of the on-going development of parent-infant therapeutic work. Certainly, in the literature there is frequent mention of the ‘ghosts’ which appear during parent-child therapy and the ways in which the therapist can try to respond to these.

It is clear that the kind of parent-child therapy I am focusing on involves the careful management of both the child’s feeling and communications and the parents’. Lisa Miller (1992) described how parent-child work focuses on both parties, even if the child may technically be the referred patient (perhaps with the presenting ‘difficulty’). Miller suggested that the therapist must aim to work with all ‘parts’ of the parents, she went on to explain, *‘This involves distinguishing between the part of the parent which is an adult, and that which is a child or a baby, and catering for both parts*.’ (p.21).

This seems to link to Klein’s (1957) approach to individual analysis, *‘That is to say, analysis makes its way from adulthood to infancy, and through intermediate stages back to adulthood, in a recurrent to-and-fro movement according to the prevalent transference situation’* (no page). Parent-infant psychotherapy could be said to follow a similar pattern, whereby the therapist tries to work with both the infant, as well as the infantile parts of adults (alongside the adult parts). Hopkins (2015) encouraged us to think about the baby in terms of their individual make up and temperament, as well as their current relationships and experiences. It could be, therefore, that the therapist must maintain a dual focus, on both parent(s) and child. The ability to work with both the parents’ presentation and functioning alongside the parent-infant relationship has been described as one of the ‘*exciting clinical aspects’* of parent-infant work (Onions, 2009: 221).

Harris and Carr (1966) highlighted how, although child psychotherapists are perhaps more commonly associated with longer term work with children, there is also a role for shorter term psychotherapy and therapeutic consultation with parents and their children together, especially in ‘*urgent situations’* (p. 13) with young children. An example is given of a short piece of work (three sessions) which took place with a 22 month old boy and his parents. Interestingly, the therapist noted, in reference to the first session with the family, that she did not give direct advice or make interpretations, but her presence and interest in both the parents and the child had allowed the parents to ‘*go on associating freely’* (Harris and Carr, 1966: 16), exploring their current difficulties and their relationship with their child.

At the heart of the literature on work with parents and their children is the idea that entering into parenthood can reawaken both positive and negative feelings within the parents (Harris, 1975). Daws (1985) described how a parent who may have experienced no major difficulties previously, can find themselves troubled and struggling in the presence of their young child. Harris (1975) referred to her experience of working with a new mother who was ‘*preoccupied with something in her internal situation’* (p. 50) which had a negative impact on the extent to which she was able to attend to or connect with her baby.

If the parent is focused on their own mental states, rather than those of the child (Baradon, 2003); then this can result in the child not having its emotional or physical needs met and hindering the development of the relationship between parent and child. Work with parents and young children (whether brief or long term) does, therefore, involve the careful consideration of both the child’s direct experiences and temperament, and the potential unprocessed experiences and memories of the parents (Lieberman, 2004[a]).

Another aim or hope of work with parents and their infants is to contain some of the parental anxieties, about their children and themselves. It has been said, ‘*Once mothers’ extreme anxieties are relieved, and they become more free to observe and reflect, babies also become less anxious’* (Rustin, 2009: 42).

Stern (1998) described how if the infant attempts to communicate something of their internal world and this is not picked up or responded to thoughtfully by the parent, in an attuned way, the child may develop ways of trying to avoid such expressions of their experience, for fear of further misattunement. Stern suggested that this might account for *'the older children's need for lying, secrets, and evasions, to keep their own subjective experiences intact'* (Stern, 1998:214). Again, we see how early experiences can manifest themselves in later difficulties. This brings to mind clinical cases where there have been themes of deception and deceit, whereby the child appears to keep all of his/her experiences and thoughts to himself/herself, effectively creating a distance between themselves and their parent(s), and other adults within their lives.

Balbernie (2001), in his paper exploring the impact of early childhood experiences from a neurodevelopmental perspective said:

> *The circuits for empathy, affect regulation and impulse control are established when the baby has consistent experiences of external, loving, emotional regulation to begin with – something which depends on parents' sensitivity, in turn derived from their own babyhood* (p. 245)

Meins (1997) referred to the idea of '*mind-mindedness*', '*to describe the mother's proclivity to treat her infant as an individual with a mind, rather than merely as a creature with needs that must be satisfied'* (Meins et al, 2001:638). This concept might be of value when carrying out parent-child therapy, in terms of how far the parent can be with the child's experience and connect to child's mind, thoughts and communications. Gerhardt (2004) suggested that 'responsiveness' from the parent is the key factor in determining the baby's likelihood to develop and thrive.

There is also a recognition, in the literature, of the importance of involving fathers both in the job of parenting, but also in therapeutic work (Barrows, 1999). The job of a father has been described as:

> *..not about being an additional or spare parent but about being able to offer a particular relationship to the baby and to the mother-and-baby-couple, offering a third position* (Daws and de Rementeria, 2015:78).

It has also been noted that fathers may experience significant changes in their roles and feelings when they enter into parenthood, including feelings of exclusion from and envy of the mother-child relationship (Wittenberg, 2008). Barrows (1999) gave two clinical examples of how involving fathers in brief parent-infant psychotherapy was most helpful, both in terms of thinking about the father's relationship with the child, and also the father's role as partner or husband.

Palacio-Espasa and Knauer (2007) wrote a chapter about 'brief mother-father-infant' psychotherapy, which took place in Italy. The inclusion of the father in the title of this work is significant, because so often we see references to 'mother-child' work or relationships, and the father is inexplicably excluded. The authors explained how involved fathers can be in this kind of work, and how their presence brings new dimensions to the therapeutic process. Working with two parents, and a child, is not always straight forward, and so the therapist is said to need to try and formulate a '*common interpretative focus'* (p.68) for the two parents. This shared focus will bring the parents together, uniting them with a joint wish, difficulty or hope, from which the work can grow.

Emanuel (2002) described working taking place in the Tavistock Under-Fives Service, emphasising the importance of holding the father in mind, even when he is absent physically or psychologically. Clinical examples were given, including a case in which the absent father was powerfully present in both the child and mother's mind, and another case where the father was, unintentionally, distanced and excluded from the mother-child relationship. The paper described the way in which the father (in reality or phantasy) could be worked with and included in the work, with positive outcomes.

I believe, especially in the field of infant mental health, as professionals we can focus on mothers and, quite unconsciously, exclude fathers. As mentioned above, fathers can feel excluded from the mother-child relationship, and so we, as therapists, have to be mindful that we do not replicate this exclusion during the therapeutic relationship. For example, even if fathers are unable to attend sessions or do not want to, it is important that they are invited, and that mothers are encouraged to share the thinking and talking done in the session with their partners. By doing so, we are trying to encourage a more integrated approach from the parents, in which, where possible, both are actively involved. In cases where there is a single mother, we may not be able to actively include the child's father, but we can, however, try to remain curious and interested in the paternal role and functioning present in the family and to keep the idea of the father alive in the room.

This idea of seeing the child within context, considering both the child's presenting difficulties but also the impact and role of the adults around them has been more recently referred to by Music (2019), whilst writing about therapeutic intervention in schools. Music suggested that when a child shows challenging or problematic behaviours, such as aggression or violence, the adults can, at times, see the child as the problem, which needs fixing, rather than thinking about the role of parents, and other professionals, in helping to address the difficulties.

There are many different hopes or aims from parent-infant work, including, the reduction of parental projections onto the child (Barrows, 1997), addressing previous trauma (Cudmore, 2007) and helping the child to communicate his or her feelings and for these to be taken in and processed by both the therapist and the parent(s) (Urwin, 2008).

The literature shows how parent-infant work can be used to address a wide variety of presenting difficulties in the child. In Pozzi's (2003) book *Psychic Hooks and Bolts*, she gives examples of her clinical work which has focused on numerous difficulties, including; separation anxiety, sleeping and eating difficulties, soiling and hyperactivity in the child.

The above literature highlights the crucial link between parent-child relationship and the child's development, in the context of the 'here and now', but also the parents' own experiences in infancy, which have a transgenerational impact. In parent-child therapy, there needs to be careful consideration for and management of the needs, communications and wants of both the child and the parent. I will now go on to say something about the role of the therapist and the ways in which the therapist can work with the parent-child dyad, or triad, making use of psychoanalytic principles.

The relationship with the therapist

One of the defining features of brief parent-child work, as used within this pilot project, is the use of therapist's counter-transference, as well as the transference, within the sessions. Despite this model of working being brief, the psychoanalytic principles of transference and counter-transference, and the awareness of unconscious communications and anxieties are still paramount (Wittenberg, 2008), as they would be with longer term parent-child work, or individual child therapy. Alvarez (1983) referred to Heimann's exploration of counter-transference and how the therapist's counter-transference '*is an instrument of research into the patient's unconscious'* (p.11). It has been suggested that the way in which the therapist responds to their counter-transference will depend on both the patient’s verbal and non-verbal expressions, as well as the therapist’s individual and internal responses (Tonnesmann, 1980).

Emanuel (2011) described how the therapist makes use of transference and counter-transference in parent-child work. It has been described how the parent, in the transference relationship with the therapist, can have an experience of a different kind of ‘parental figure’, which may differ considerably from their experiences with their own parents in reality and the internal parental figures within the parent (Baradon, 2005). When working with a child and their parent(s) the therapist is met with projections on multiple levels and must be mindful of how these are managed and responded to. Watillon-Naveau (2010) described how seminar discussions with colleagues and making notes after sessions are paramount when conducting parent-child work. Within this project, discussions with both my clinical supervisor and my research supervisors, as well as peers, helped me to become aware of some of the projections I was receiving and I was then more able to make use of my counter-transference in a helpful way, either during the sessions, or during my thinking and processing in-between sessions. This brings to mind my previous comment regarding how the therapist can observe both the patients, as well as themselves.

Whilst making use of the counter-transference and transference is a focal part of parent-child work, which allows us to gain deeper understanding of the feelings within both the parent and the child, and differentiates this model of working from other parent-child work, it seems that we must also be mindful of how far we make use of these within brief work. Within individual psychotherapy, it can take time to ‘gather-up’ the transference and make sense of what we, as the therapist, are feeling during sessions (through our counter-transference). In brief work, we clearly have less time to do this, and we must be mindful of how far we feedback on our observations to the families.

Edwards and Maltby (1989) described their work which was based on the Tavistock Under-Fives brief model of intervention. They helpfully explained how the tools of transference and counter-transference must be carefully considered within family work, because it will differ from the use in work with an individual, especially when the intervention is brief. It was said, '*Given the intergenerational, intrapsychic and interpersonal dimensions of each family, it can seem like an enormous and unwieldy load, especially given our stated brief of five sessions'* (p. 119). It has also been suggested that it can be harder to bear the counter-transference, and the powerful projections from parent to child, and parent to therapist, in parent-infant work as opposed to in individual work (Hopkins, 2008). It is, however, perhaps important to note that it has also been suggested that the main focus of parent-infant therapy is the parents' transference to their baby, rather than the transference relationship to the therapist (Hopkins, 2008).

The unconscious communications which can be accessed through our counter-transference can be made use of alongside the more conscious communications within the room, and between the child and therapist and parent and therapist. Salomonsson (2015) described parent-child work, which built upon the concepts of parent-infant therapy. The reader is told how the relationship between the child and the therapist can provide helpful information about the parent-child relationship. Salomonsson stated:

> *Once the therapist directs his attention to these strivings of the baby, he may notice that the child seeks to involve him as well for containment. Interactive*

> *patterns similar, though seldom identical, to those between parent and child might commence between the two. This phenomenon forms an important leverage for therapeutic work.* (p. 4)

This highlights the importance of the relationship between the therapist and the child; the therapist and the parent; and the therapist and the parent-child dyad. Barrows (2003) helpfully described how this kind of work can focus on three main areas; the parents' mental state; the child's mental state and relationship between the parent and child. Barrows highlighted the importance of the 'containing' function of the therapist and how both the child's presenting difficulty is thought about, alongside the experiences of the parent and what they might bring to the parent-child relationship.

The therapist may observe some very powerful projections from the parent(s) onto their child. Alvarez (2017) referred to a piece of clinical work in which *'a fairly non-violent child is seen as violent by a possibly quite paranoid caregiver'* (p. 331). We thought earlier about the ways in which the child projects onto their parent(s), but another feature of work with the child and the parent is thinking about what the parent projects onto their child.

Furthermore, the therapist can find themselves drawn into conflict between the parents, in which each parent feels the therapist is an 'ally' of the other parent (Palacio-Espasa and Knauer, 2007), and there may also be feelings of envy and jealously from the parent(s) to the therapist (Klein, 1932). These projections have to be addressed and worked on during the sessions, as far as is possible.

The therapist's awareness of these projections and feelings is a key part of psychotherapeutic intervention and it is hoped that by helping to bring awareness to these different levels of communication, some change or development will be possible.

I will now look, in more detail, at literature which has explored the ways in which parent-child work, including brief work, can elicit change, in both the child and the parent(s).

Potential for change

There has been much written on the potential for change within parent-child work, even if what is offered would be described as, 'brief work', where families are only often a limited number of sessions. Hopkins (1992:15) suggested, '*The capacity for rapid change in infant-parent relationships is a reflection of the flexibility both of the infant and of his parents'.* This acknowledgement of the potential for change in both the child and the parents is echoed within other literature. With regards to the children, it has been highlighted how there is a great capacity for change and development, owing to the developmental processes at work within this young age group. Hopkins (2015) described how receptive young children are to change, and Rustin and Emanuel (2010) referred to the 'thrust' of the child's development as one of the contributing factors in this ability for change. Miller (1992) captured this clearly in the idea of '*a time of naturally high-speed growth and development'* (p. 20).

This capacity for change could be explained in terms of the 'neuroplasticity' within young children. We know that the brain is most primed for growth and development within the first two-three years of life (Balbernie, 2001), hence work with this age group having such potential for change.

This potential for change and development is not just present in the children, but in the parents too. Wittenberg (2008:18) suggested, *'To offer understanding to parents burdened or unable to manage the disturbing feelings aroused by their young baby seems to be, therefore, of quite particular importance, a piece of preventative mental health work of the first order'.* There is something very important about the idea of this early support, which could perhaps be deemed as more ‘preventative’, trying to address difficulties quickly, before they become entrenched and embedded.

It should also be noted, however, that questions have been raised about the efficacy of so called ‘brief’ work, and Barrows (2003) referred to the idea that difficulties can be addressed in a very short number of sessions (for example, two or three). He stated, ‘*Such accounts can seem almost magical: the therapist is left in despair or puzzled – the family return next time and all is resolved!’* (p.283).

Barrows was in support of parent-infant work, and expressed clearly the value and importance of this way of working; however, he also attached a note of caution, suggesting that short-term models of working may not always be effective in addressing difficulties and extended approaches may be required. The issue of duration was also touched upon by Pozzi (2003) who described two methods of working, the first, in which families were offered the brief model (i.e. five sessions, with a possible additional five), and the second, which involved longer, open-ended working, if the initial brief intervention was not sufficient. Pozzi referred to how, even if longer term work is needed, the brief work can function as an informative assessment or introductory period.

We may, therefore, need to think carefully about the duration of the work, and approach referrals with flexibility. We must hold in mind the individuality of the family, and how they respond to the work and the therapist.

We can see that there are several factors to consider when working with a child and their parents together. The therapist must thoughtfully and sensitively manage and respond to the needs, communications and projections of all parties involved, and there is a hope that both child and adult can be actively engaged in the work. With this in mind, I will now go on to look at how parent-child work has been carried out in practice. I will focus predominantly on a model of brief parent-child work which was established by the Tavistock Clinic in London, I will however, also provide a summary of the context from which this model developed.

iv. Parent-child work in practice

In the 1970s Fraiberg and colleagues set up what was known as an ‘Infant Mental Health Programme’ in America, the aim of which was to work with parents and their young children, focusing on the child’s presenting difficulties, in addition to the ‘ghosts’ of the parents’ pasts (Fraiberg et al, 1975). This early model of working was referred to by the clinicians, as ‘*psychotherapy in the kitchen’*, because they would carry out the intervention in the family home.

Since Fraiberg’s and colleagues’ programme of intervention, work with parents and their young children has continued to grow. Individual therapists have also developed their own services which have contributed to the development of theory and understanding regarding infant mental health or work with parents and infants. Dilys Daws (1985), for example, described her work with mothers and babies in a health centre. Her work was defined as brief psychotherapy, and was based on the premise that mothers can experience difficulties with their young infants which relate to their own experiences in their lives. The mother’s previous experiences can come to be reflected within the current mother-child relationship.

In the 1980s, The Tavistock Clinic, established an ‘Under-Fives Service’, with Lisa Miller and Alan Shuttleworth providing key contributions to the development of this provision (Pozzi-Monzo and Tydeman, 2007). Interestingly, Lisa Miller (1992) differentiated this service from other provisions within the Tavistock Clinic by the fact there was not a single referred patient, but rather the work focused on the parent-child relationship and the parents' current concerns about their child. It is on the Tavistock's model of brief work with children and parents which I have based my intervention within this pilot project.

It has been said that some of the defining features of the Under-Fives Service were flexibility, curiosity and an informality (Miller, 1992 and Emanuel, 2006). It seemed that approachableness, understanding and a non-rigid approach were all at the core of this service. The clinicians offered brief intervention, starting with five sessions, but with flexibility to offer another five, if required (Emanuel, 2011).

Cudmore (2007) explained that the work within the Under-Fives Service tried to attend to experiences which occurred in the perinatal period, because there was a recognition that difficult events during this period can have, *'serious repercussions on the quality of the relationship between the parental couple and between the parents and infants as they grow their child'* (p. 198).

There are many useful papers which give accounts of work carried out within the Tavistock Under-Fives Service. These include, Likierman (2003), Cudmore (2007) and Wittenberg (2008). Such papers provide helpful overviews of brief work with parents and infants, drawing upon theory and clinical experience. They are brought to life through thoughtful vignettes from particular pieces of work carried out within the service.

I will end this section by giving an extract from one of the clinical case studies written by Emanuel (2006), taken from her work in the Tavistock Under-Fives Service. I have chosen this particular section because I think it demonstrates well the way in which brief parent-child psychotherapy works, and how the therapist responds to both the child's play and communication, as well as the parental concerns; whilst keeping in mind how the relationship with the therapist may link to the parent-child relationship and the parents' own experiences. The first extract is from a clinical vignette, whilst the second part is the therapist's discussion of this material.

> *She recounted how Mario and his friend Peter had been riding their trikes in the park, racing to the gate, when Mario had deliberately crashed his trike forcefully into Peter. The trike had overturned and Peter had fallen heavily, banged his head on the cement path and been badly hurt. As we were speaking Mario was gouging the plasticine off the car, and said, 'It was an accident.' 'No,' repeated his mother, 'I don't think so.' At that moment Mario tore the last bit of plasticine from the car, moved over to the corner of the room, sat face down and murmured, 'I didn't want Peter to win.' I felt touched, and said Mario seemed to feel it was too hard to be the small one and to come last, so Peter had to have the hurt, upset little boy, feelings. He said 'Yes' miserably.'* (p. 74) *…*
>
> *I felt that mother, by not colluding with his view that this was 'an accident', had created a firm, but understanding, parental couple with me, which provided Mario with the containment to verbalise his difficulty. Mother's ability to stand up to him, despite her exhaustion (managing to embody both maternal and paternal functions), seemed to relieve his anxiety* (p. 75)

We can see the way that Emanuel and Mario's mother demonstrated a functioning parental couple, within the session, which helped the child (Mario) to share some of his 'little boy feelings', which were often hard to reach and projected into others. Without giving the full family history, it is important to note that in earlier sessions, Emanuel had noticed how Mario's parents, to an extent, '*idealised their son's fiery*

‘Mediterranean’ temperament’ (p. 72), so again we see the significance of this extract, because Mario’s mother was able to help him to recognise and communicate his more vulnerable feelings, instead of his ‘fiery’ aggression.

The case study can provide rich clinical evidence of change and development, within the parent and/or child, as a result of the therapy, and is one way of assessing the treatment’s outcomes. I will now give more detail on the way in which outcomes or effectiveness of treatment have been explored within the literature.

v. Assessing the outcomes

Some authors have tried to assess the levels and types of change which can be achieved through parent-child work. Some of this literature relates specifically to brief psychotherapy, whilst some addresses different models of parent-child work, with varying durations. The need for evidencing the efficacy of treatments fits with the current political climate within the NHS, whereby the efficacy and effectiveness of treatment methods must be shown, and approaches need to be ‘evidence-based’ (Rustin, 2003: 138).

Case studies are widely recognised as the primary research method used in psychoanalytic psychotherapy (Rustin, 2010), and they are valued because of their ability to provide *‘clinically rich and meaningful’* data (Midgley, 2009: 86). Some examples of such studies include Pozzi’s (1999) accounts of her work with two families with children under the age of five years old. Pozzi gives detailed descriptions of the clinical cases, as well as providing a theoretically informed summary of the work. Onions (2009) gives three examples of different kinds of parent-infant work offered by OXPIP (the Oxford Parent-Infant Project). These include individual work with mother and child, group work and work involving the use of video recordings. Meersand’s

(2001) account of work with a mother and son focuses on the way in which play was used during the therapy in order to encourage self-reflection, which ultimately helped the mother better understand both herself and her son.

As demonstrated earlier in this review, case study write-ups often involve the use of theory as well as clinical vignettes taken from the therapy sessions themselves. Whilst the use of standardized outcome measures may be used widely with NHS work, particularly, to assess change, the session material itself also provides a wealth of information about the changes and developments made possible through parent-child work.

In more recent years, there has been a movement away from relying solely on case study material and researchers have begun to assess levels of change by using more structured outcome measures. Cramer et al (1990) conducted research assessing the levels of change by using objective outcome measures. They offered a group of children (under 30 months old) and mothers brief (up to ten sessions) psychodynamic parent-child therapy, whilst a control group was offered therapy based on an 'interactional guidance' approach. Various outcome measures were used to assess the child's difficulties, as well as the parent-child relationship, including the Beck Depression Inventor, the Symptom Check-List and the assessment of mother-infant interactions.

The two models of intervention differed in their approaches; the psychodynamic therapy included the use of interpretations, but not direct guidance, whilst the interactional-guidance technique involved the use of video recordings and attempts to coach the mother's interactions with their child. Interestingly, the effectiveness of both treatments was found to be very similar. Positive changes occurred in different areas, including in the child's presentation, in the parent-child relationship and in how the parent viewed or understood the child and themselves. Importantly, it was found that these changes were, in general, maintained at a follow-up six months later. There were some slight differences in the nature of the changes that occurred, between the two groups, which seemed to link to the nature and focus of the specific intervention, but the overall conclusion was that brief work can be helpful for mother-child work both in the short and long term. Unfortunately, again fathers were not included, although there was reference to the representations of the fathers (in the mothers' minds) pre and post intervention.

Fonagy, Sleed and Baradon (2016) conducted a randomized control trial investigating how parent-infant psychotherapy, for mothers with mental health difficulties and infants under one year old, compared with a control group receiving primary care. They measured various outcomes including: infant development and parent-infant relationship, such as the maternal representations of the child, the maternal psychopathology and the attachment between infant and mother.

The findings showed that, whilst the two treatment methods led to very similar outcomes for many of the measures, there was a significant improvement in the maternal representation of child in those mothers that had received parent-infant psychotherapy, as opposed to the control group. Although there were limitations to the generalisability of this study, including the small sample size and participant attrition rates, the results were significant none the less. They highlight that what differentiates child-infant psychotherapy from other treatment is the ability for it to instigate changes in the way in which the parent views their child, which will have significant impacts on their attachment and relationship on-going. We may consider these maternal representations as both conscious and unconscious processes.

Jones (2006:296) drew upon her clinical experience, offering parent-child therapy, explaining that she focuses on three areas of change during this work:

> *(1) firstly, the level of observable behaviours between infant and parent and what the behaviours mean;*
>
> *(2) secondly, hypotheses about the influence of unconscious processes;*
>
> *(3) and, thirdly, the level of conscious narrative construction between therapist, parent/s and baby*

From this, we can see how parent-child work can address different areas and levels of communication - not only between the parent and child, but also with the therapist themselves.

Lieberman and colleagues' (2005) randomized controlled trial found that parent-child psychotherapy was an effective treatment for pre-school aged children who had experienced parental violence, and it was said to promote, *'a relational process in which increased maternal responsiveness to the child's developmental needs strengthens the child's trust in the mother's capacity to provide protective care'* (p. 1246). It should be noted that this project involved the participants being offered one year of parent-child psychotherapy, so it was not assessing brief work. Nonetheless, the results are of interest because they relate to pre-school aged children, (which accurately reflects the age of the children involved in my project), whilst much of the other literature I found focused on treatments with infants.

Barlow and colleagues (2016) conducted a systematic review exploring the effectiveness of parent-infant psychotherapy. The authors reviewed existing studies and projects, comparing either parent-infant psychotherapy with a control group, or another alternative treatment method. The review concluded that although there were some improvements in terms of the child's attachment security following parent-infant psychotherapy, there was no clear benefit of this kind of work, as opposed to the others methods used. However, despite these findings, the authors stated:

> *Indeed, the delivery of services to children during the first two years of life could be effective in reducing some of the later demand for specialist child and adolescent mental health services, and although the findings of this review are currently inconclusive in terms of the effectiveness of parent–infant psychotherapy per se, or indeed relative to other methods of working, they nevertheless support the increasing body of evidence suggesting that brief, dyadic, attachment-based techniques of this sort can bring about improvement in children's attachment in high-risk dyads, with significant potential long-term benefits for the child.* (p. 477)

Whilst this review suggests that parent-infant psychotherapy is not the only effective method for working with difficulties in infancy, it does demonstrate the need for some specialist interventions and support within the field of infant mental health.

Parent-child work has been developed not only across the United Kingdom but globally as well. In the book, 'Innovations in Parent-Infant Psychotherapy' (Pozzi-Monzo and Tydeman, 2007) there are chapters exploring how parent-infant therapy has been used in different countries around the world, including Italy, Brazil, Japan and South-Africa. There are clearly distinctions between the models offered in the different countries, although all of them are underlined by the principle that working with the parent and infant together can bring about positive change in terms of the outcomes for the child.

Berg (2007), describing parent-infant work in South-Africa, made an interesting point about the cultural understanding of physical vs. psychological pain or distress, and she described the separation of these two elements as a *'western, Cartesian concept'* (p. 217). In the South-African community, there were very real issues of illness and deprivation, so it was a task for the therapists to try and separate out which issues had a physical cause, and which had a psychological or emotional element at their core – the distinction was not always initially clear. The effectiveness or relevance of different treatment methods will, therefore, be culturally subjective and researchers and clinicians alike must hold this in mind.

There is also a considerable amount of literature on the nature of 'brief' or time-limited work with children and families, although it is important to note that the definition of what defines 'brief' work appears quite subjective. Toolan (2003) wrote about the parent-infant counselling clinic based in North-East England, which offered brief work, usually up to five therapy sessions. Toolan suggested:

> *Misgivings about whether brief intervention can ever be 'enough' are of course legitimate. However, the lessons we have learned from the infants and parents we have been working with have given us a firm conviction that this is worthwhile and rewarding work in which the principles of emotional containment can bring real benefits.* (p. 70)

This is helpful when we consider that the families in my project were only offered five sessions, which may seem like a very brief piece of work, especially when we think back to Barrows' (2003) previously mentioned comments regarding the potential limitations of very short-term work. It seems important to hold Toolan's reflections in mind, because although short-term work may not entirely alleviate the presenting difficulties and patients may be left wanting more; we can hope that the work (no matter how brief) can help to contain some of the anxieties and concerns and either begin to initiate change, or function as a form of in-depth assessment which may lead onto further work. The ability to offer containment is recognised as one of the key functions of therapist in this work (Hopkins, 2008). This brings to mind Winnicott's (1951) concept of 'good enough' and the idea that, at times, a clinician's intervention may be viewed in this way too (Biseo, 2014) something 'good enough' which hopefully allows further positive development and growth.

To summarise, in this chapter I have explored the key contributions to the field of parent-child psychotherapy, particularly brief models. I began by referring to some of the early contributions, which formed the basis of psychoanalytic thinking, including the work of Freud, Klein and Bion. These authors explored some of the fundamental terms upon which we rely so heavily during psychodynamic work, including stages of development, the processes of projection and containment and importance of the early relationship between child and parent. I then went on to make reference to literature which has addressed the way we understand children and their development, including the use of infant observation, some theories of child development and a summary of some contributions from the field of neuroscience.

The next section addressed some of the key considerations and processes which may be involved within parent-child psychotherapy, particularly when a brief model of intervention is used. Thoughts about the use of counter-transference and the role of the therapist were mentioned, as well as ideas about the focus of work. The capacity and potential for change was also mentioned. The literature in this section has proved most helpful to me both during the planning stages of this project, whilst I was trying to anticipate what this method of working would involve; as well as during the clinical stage. Reminding myself of the processes and applications of other therapists' work helped to reassure, focus and encourage me in my own.

I then gave some information about a pre-existing model of brief parent-child work, developed by the Tavistock Clinic. I provided a summary of the model, as well as some reflections from therapists who have worked within this service, or have adopted this model themselves.

Finally, I summarised literature which has addressed how the outcomes of parent-child psychotherapy can be measured. I referred to literature which explored the outcomes of brief work, as well as parent-child work more broadly.

Running through this literature, as a whole, is the importance of the early relationship between a child and its parents, and factors which may affect or disrupt this relationship. That said, the literature has also highlighted aspects of individual development in the child and the ways in which independence and freedom can be encouraged in children. Parent-child psychotherapy offers a unique approach to infant mental health by working with the child and the parents, past and present, on both conscious and unconscious levels. These processes can be made use of in longer-term therapy, but, as we have seen in the literature, they are also compatible with and helpful for short-term, or brief therapeutic models. This method of working can help to uncover difficulties within the parent-child relationship, drawing upon the parental experiences and influences, as well as the individual constitution of the child, with the aim of helping the family to develop a shared or mutual language of communication and understanding.

Methodology

I shall begin this chapter with a summary of the research aims and the project design; I will then give some information about the ethical processes involved, before exploring the methods used in more detail. The methodology will be separated into two areas; first, those used in the therapy sessions themselves, and second, the outcome measure methods used. I shall then go on to give information about the sample of participants used, including the inclusion and exclusion criteria, before exploring how analysis of the data was done. I will conclude this chapter with some thoughts about potential issues or limitations with the methodology, including some thought about validity, and challenges of being both clinician and researcher. Throughout this chapter, I will refer to some of the relevant research literature which I have read and found helpful during the planning and carrying out of the intervention.

During this section and this thesis as a whole, I will occasionally refer to notes from my ‘research journal’. This was a book in which I recorded some of my thoughts, feelings and experiences during this project – from the initial stages of writing a proposal, right through to the data analysis and writing up. I found writing this journal helpful, as it gave me a place to think about and digest some of my experiences. It has also been helpful to look back at the journal, during the project write-up, in order to think about the different states, phases and feelings I went through. As a psychotherapist, writing down notes after sessions is a key part of our training and on-going work, so I believe the journal writing also functioned in a similar way, giving me a chance to reflect on the facts of what had happened and what needed to be done next, in a very concrete ways (often taking the form of lists!), but also giving a chance to reflect on my feelings, countertransference and thoughts.

i. Research question and aims

The primary aim of this research was to trial an under-fives' service (similar to that developed at the Tavistock Clinic), in a CAMHS team which had not offered this kind of work specifically before, and to learn about the responses of families and CAMHS staff. Rather than having a hypothesis as such, I set about hoping to learn and discover more about this kind of working. The project involved recruiting families, with children under the age of five years old, who were experiencing one or more difficulties, and these families were offered five therapeutic sessions. I hoped to see how this kind of work could be adopted within a generic CAMHS team, and how it was received by the families involved.

Owing to this method of working being new to the team, I was interested in finding out how my colleagues responded to this work taking place. Gaining qualitative or quantitative data in this area was beyond the scope of this piece of research, so I decided to try and gain some less structured feedback from the team.

Before the clinical interventions had begun, in the team's multidisciplinary meeting I gave a short presentation which introduced the model of working to the team, and informed them of the plan for the pilot. After the clinical interventions were completed and data analysis had been done, I provided a second presentation to the team. Both of the presentations involved a short PowerPoint presentation, followed by discussion. The team meeting is attended by any clinicians present on that day, and incorporates people of different clinical backgrounds. These presentations were an opportunity for me to share information about my project and what the interventions consisted of, to hear about my colleague's views of this pilot and work with under-fives generally, taking place in the clinic, and to think together about the current provisions for under-fives in the local area.

ii. Research design

Research paradigm/theoretical framework

This project was qualitative in nature and involved the analysis of data which was generated through clinical practice. The study used a prospective research design, whereby the project aimed to explore the impact of a specific intervention, rather than retrospectively looking back at an intervention which had previously taken place. I trialled an under-fives service (offering brief parent-child psychotherapy) within a generic CAMHS team and explored the acceptability and experience of the treatment for the families. In addition, I also gathered some information about how the trial was received and understood by the other clinicians in the team. This kind of work had not routinely taken place within the CAMHS team before, so a pilot study enabled information to be gathered about how this kind of work was received by and suited to the needs of the team, and the families that participated.

It is recognised, in the literature, that difficulties in young children should not be seen in isolation, and brief models of parent-child psychotherapy can offer a space for families to think about the child's mental health and wellbeing in the context of the wider family functioning and relationships.

Rationale

The pilot project made use of a pre-existing model which was developed at the Tavistock Clinic, but subsequently adopted by many other services and provisions. My reason for conducting this research was not primarily to test whether this model could work, because not only would my sample size not allow for this kind of conclusion, but the value of this work has been recognised and proven previously. The aim of my research was to see how this kind of model can be adopted within a generic CAMHS team and learn more about the experience of this model from the point of view of the families involved and the wider team.

It should be noted that, whilst my project was based on the Tavistock model, there were some differences in the delivery of the intervention. One of the key features of the Tavistock's service was the ability to see families without delay, and this linked to the fact that most of the referrals were self-referrals, to which the clinicians involved aimed to respond as quickly as possible, acknowledging the '*courage*' (Miller, 1992: 19) which was evident in parents asking for help.

Due to the limitations associated with having only one researcher and clinician, as well as the procedures in place within the CAMHS team, this kind of quick response was not possible during my project. Referrals had to be received from another professional, and then the families had to go through an initial assessment with one of my colleagues. Therefore, whilst this project made use of a pre-existing model, there were some differences in the delivery of the intervention, mainly in relation to the referral and assessment processes.

iii. Ethics

Ethical approval

Ethical approval for this project was gained through two different bodies; The University Research Ethics Committee (UREC) through The University of East London (UEL); and the Health Research Authority (HRA) (see appendix i and ii). HRA approval was required, in addition to UREC approval, because my project involved NHS participants.

As part of the HRA ethical approval process, I had to attend a panel interview in January 2018. I was informed that this would be necessary as there were concerns regarding the potential for the therapeutic intervention to cause distress to the children involved. This was puzzling to me, as I very much hoped (and believed) that the intervention would alleviate distress, rather than cause it.

The panel interview was quite an anxiety-provoking process for me and I recall the feeling of being faced by approximately twelve professionals, from various backgrounds. In my research journal I wrote, *'I felt as though I had a group of hard-to-please parents around me, who were making many requests and had high expectations of me – the child'*. I also wrote about my feelings of 'powerlessness' and a sense that my 'language' was not easily understood by the professionals involved in the ethical approval processes. This seemed poignant because I was, even prior to the project having begun, put in touch with some of the feelings that the children who participated felt at times. Furthermore, once ethical approval had been gained, I wrote about feeling like a new parent, *'Now I had the approval, I felt unprepared and somewhat alone with the research project 'baby'. What will I do once the 'baby' is born? Am I qualified for the job?'*

Ethical considerations

There were not deemed to be high levels of risk associated with this piece of research, because of the nature of the intervention and the setting in which it was conducted. It was, however, possible that during the sessions sensitive or difficult topics could have been discussed and this could have potentially caused distress to participants. If a participant had become very upset or unsettled, they were able to end, or pause, the session at any point. If I had judged that the parents/adults were discussing topics which were unsuitable for discussion in front of their children, I would have suggested that the parents and I continued these conversations outside of the therapy session.

If the families required on-going work beyond the remit of the trial, I planned to communicate this need to the referrer, and the families would be offered treatment as usual, within the relevant pathway; or they would have been referred on to the relevant services, if required.

If any safeguarding concerns had arisen during my research, I would have discussed them with the family and my line manager, prior to referring to our Trust's safeguarding team and social care, if required. Participants were told, before the treatment began, that confidentiality would have to be broken if there was serious concern about their, or somebody else's, safety, in line with Trust policy and professional codes of practice.

All of the sessions took place within a CAMHS clinic, where other members of staff were always present and the team were also made aware when I met a family for the first time.

Consent was gained from the parents, prior to participation in the project. I had designed a consent form, for completion by the child; however, given their young age, and following discussions with my supervisors, I decided that I would not use this form, because, if the children did complete it, they would be unlikely to understand what the project would involve and, therefore, consent would not be fully informed. I did, therefore, ask the parent(s) to complete a form giving their adult consent, and then a separate form was completed by them, on behalf of their child (see appendix v and vi).

iv. Choosing methods

Part A - the therapy

The families were each offered five therapeutic sessions, involving the parent(s) and child. Although the Tavistock Under-Fives model offered five sessions, with the possibility of an additional five sessions, because this was a small, time-limited piece of research, carried out by one researcher, I decided to limit the intervention to only five sessions per family. The families were told that they could bring whoever they wanted to bring to the sessions. The sessions were all attended by mothers, although some fathers did attend for some of the sessions.

The therapy sessions were based on psychoanalytic principles, which involve the therapist receiving and working with both the conscious and unconscious feelings and communications from the patient (Wittenberg, 1982). This included considering the relationships within the family and also between the family and the therapist.

After each therapy session, anonymised process notes were written, as per usual practice within psychoanalytic psychotherapy. Our process notes make use of our observational skills and so we try, as best as possible, to record not only what happened and what was said, but also what we observed between the parent and child, as well as between the parent/child and us (the therapist). In psychotherapy, these notes also include reflections on how we felt during the session, comments on the mood and interactions between those present, and observations about our countertransference (Watillon-Naveau, 2010).

Every session was written up, although not all sessions were analysed. I will say more about this in the ‘Analysis’ section to follow.

Part B - interviews and outcome measures

Interviews: each intervention began with a semi-structured interview, prior to the commencement of therapy. Although these interviews were based around a semi-structured interview schedule (see appendix viii), in line with the nature of psychoanalytic psychotherapy, I wanted to keep these conversations open and flexible. With this in mind, therefore, I did refer to the question/prompts when needed, but also allowed the parents to guide the conversation as desired.

I based these interviews on five question prompts – four of which addressed the current situation, the onset of the difficulties and the family's current functioning. The fifth question referred to the setting and rating of goals for the intervention. For the purposes of this section and the findings sections, I refer to the goals as a separate outcome measure to the interviews.

After each session, I wrote process notes of the interviews. Some handwritten notes were recorded during some of the interviews, where appropriate, but in general the writing up of the interviews was done afterwards.

These interviews were repeated at the end of the intervention, post-treatment. The same questions were revisited and the goals were reviewed.

Goals: goals were set by each of the families in the pre-treatment interview, and these goals were then re-rated in the post-treatment interview. The setting of goals is an outcome measure regularly used in the clinic, so I wanted to incorporate this into the project, in order to try and make the outcomes as valid and reliable (in terms of routine interventions in the clinic) as possible.

Goal Based Outcomes (GBOs) are used routinely within the NHS as a way of evidencing, evaluating and commissioning different treatment methods (Law, 2013).

The aim of a goal is to focus on what the young person (or parents/family) want to achieve through the intervention. Goals should, therefore, be service user led, rather than clinician led, although there is clearly some discussion and collaboration between service user and therapist in order to ensure the goals are as meaningful and achievable as possible (Law and Jacob, 2015).

Each family was asked to set a goal which addressed the current problems or difficulties that they wanted to focus on during the therapy sessions. They were asked to rate their goal from zero to ten, zero representing that the goal is currently not being achieved at all, and ten meaning the goal has been entirely met. The families were able to set a maximum of three goals each, although in fact only one or two goals were set by each.

Experience of Service Questionnaire (ESQ): at the end of the interventions, alongside the post-treatment interviews, parents were also asked to complete an ESQ (see appendix ix), which is a patient satisfaction measure. Again, this is an outcome measure routinely used in the clinic, and fits within a wider health policy drive for service user feedback to be captured by services such as CAMHS (Brown et al, 2014). There are two versions of the ESQ, one for children and one for parents/carers, whilst there is value in gaining satisfaction ratings from children within CAMHS (Young et al, 1995), given the young age of my participants these questionnaires were not suitable. I was not aware of any other service user feedback measure which is aimed at children under the age of five, so parental feedback was relied upon.

The ESQ is designed to assess how the participant has experienced an intervention or service, exploring different elements of the service user's experience, including in relation to the therapist and the intervention, as well as the building and site provisions.

The ESQ is made up of two parts, the first includes twelve statements which the participant has to rate as ‘Certainly True’, ‘Partly True’ ‘Not True’ or ‘Don’t know’. The second part asks three open questions, and leaves space for the participants to answer in their own words.

It is important to note that the ESQ is usually given to service users at the end of a treatment and they are given an envelope to return the completed forms in, in order to protect anonymity and encourage honest and reliable answers. However, because this was a research project, involving only a very small number of participants, it was not possible to protect the participant’s identity. The forms include a section which asked about the child’s age, gender and ethnicity, and owing to the sample size, these details would have identified the family. Whilst I actively encouraged the parents to be honest and open in their feedback, and I made a point of not collecting the ESQ until the end of the session, I understand that the fact I was going to be receiving the questionnaires directly, and that the information was identifiable, may have affected the answers given.

Follow-up

I had planned to offer each of the families a six month follow up, where possible, in order to assess the long-term efficacy of the treatment, as demonstrated in Lieberman et al’s project (2006). This was going to take the form of a one off telephone call or appointment to review how things were going. However, because of the time constraints of the project, and the post-intervention pathways the families took, this was unfortunately not possible. I will say more about this in my conclusions chapter.

The intervention in practise

I will now give more detail regarding what the work looked like in reality. I include this information because I believe it to be relevant when considering how this kind of work was received by the families.

Pre-treatment interviews: my first participant, Scott, (I will introduce my participants in the next section), accompanied his mother to the initial interview. I found that it was quite a challenge to manage the child's needs whilst thinking with the parent about the interview questions and the presenting difficulty (or difficulties). For all of the following families, I did, therefore, request that the parents attend the initial interview on their own; however, one other parent (Leila's mother) did bring Leila along. Interestingly, it was only mothers who attended this interview and in general any liaison during the project was done with the children's mothers. Amy's mother opted to complete this interview by telephone, as she said that it was difficult for her to come to the clinic.

The therapy sessions: the configuration of who attended which sessions changed, session by session, for each of the families, except Scott's, as he and his mother attended all of the sessions. For the others, all of the sessions were attended by the referred child and their mother, but we were also joined by siblings and fathers for some of the sessions. Harry's father attended all of the therapy sessions except the last, whilst all of the other fathers' attendance was very much determined by their working patterns. Some of the parents brought their other children along to some of the sessions, except Scott's mother and Leila's parents.

The sessions took place between May-October, with a majority of the sessions taking place during the school holidays. All of the families attended all of the offered appointments, with none being cancelled at short-notice. I aimed to see the families weekly, but this was not always possible, and I did, on some occasions, have to be quite flexible with the times or days of appointments offered in order to fit with the families' schedules. Amy's mother did ask to cancel the last therapy session, because of concerns about Amy missing school (the other appointments had taken place during the holidays), but after I explained about the significance of this ending and my thoughts about it being an important part of the work, she did bring Amy to the appointment.

In terms of the writing up of the process notes, following the sessions, I did wonder if the session number, or the position in the research project that the family were seen would have an impact on the session write-up lengths. I did a brief comparison between the session lengths, looking at each session (one, three and five) and each family. This did not reveal any noticeable trends and it appeared there was no significant difference in terms of the order in which the session occurred and the word count.

Post-treatment interviews: the post-treatment interviews were generally harder to organise, and I experienced that it was quite challenging to get some of the parents to commit to attending this review; whilst other parents expressed a wish for this appointment to take place sooner than offered. Amy's mother again opted to complete the interview by telephone, but this was somewhat difficult to arrange, and she was quite ambivalent about committing to a certain time.

Only mothers attended the post-treatment reviews and, as arranged, no children attended.

v. Sampling

A purposive method of sampling was used within this project. Purposive sampling is used when '*the nature of the research questions necessitates that certain criteria be used to determine who or what goes into the sample*' (Salkind, 2010: 1298). I aimed to recruit between 4-6 families, each of whom had at least one child under the age of five who was experiencing some difficulties that were affecting their, or their families' functioning and well-being.

Due to the research having been carried out by one individual and the fact it was a pilot study, it was decided that between 4-6 families would provide a sufficient amount of data, whilst being manageable in terms of analysis. Although this small sample size limited the generalisability of the results, I hoped that the findings would provide insight into how this intervention was received by the sample group, within the particular setting.

Inclusion criteria

The participants in this trial were children under the age of five years old, who had been referred to the CAMHS clinic. The child could have been experiencing a range of difficulties, including issues with sleeping, feeding or attachment, which were having an impact on their, or their families, functioning and wellbeing.

The work involved working with the referred child and their parent(s) and whilst I aimed to work with both parents where possible, I was also flexible and worked with whatever family configuration arrived to the appointments.

Exclusion criteria

In terms of exclusion criteria, I had planned not to include families that were involved in court proceedings; safeguarding concerns; currently experiencing domestic violence, or those for whom severe parental mental health difficulties were indicated at the point of referral.

If the families had already been accessing mental health support, or the child had severe developmental difficulties and would require a specialist service, they would have also been excluded from this research. Furthermore, if the family had required an interpreter in order to participate, I would have been unable to involve them, owing to the level of complexity this would have added in terms of the communication.

Owing to the small scale of this research, the above exclusion criteria was deemed necessary in order to try and reduce any complications which might affect participation or outcomes of the research. In reality, at least two of the parents involved in the project did have their own mental health difficulties, but these were not considered to have impacted significantly on their involvement or engagement in the work. For other families, parental mental health concerns became apparent during the work.

Recruitment

The families were recruited by referral directly to the CAMHS team. Prior to recruitment, I met with the screening team (who convene daily to review new referrals), in order to introduce them to my project, and inform them of my inclusion and exclusion criteria. I asked that any potentially suitable referrals were discussed with me directly.

Those families which I deemed to be suitable for the project were then contacted by the team, in order to be offered an initial assessment with a colleague. I met with the allocated assessing clinician and gave them a brief information leaflet (see appendix

iii) to pass onto the family, if appropriate. I also asked the colleague to gain initial verbal consent from the families to be contacted by me, to find out more about the project. If the family did not want to be contacted, they would have received treatment as usual.

The families had to wait for allocation for an initial assessment, and this waiting time was typically four-eight weeks. Therefore, from the point that a referral was screened by me, to the point where I was able to make contact with the families was typically two months. This waiting period again highlights the difference between the traditional Tavistock Under-Fives model and the intervention offered in this project.

The families had to meet with one of my colleagues for a full initial assessment and, whilst there were guidelines for how these assessments should be carried out, they did vary, to some extent, depending on who the assessing clinician was. Furthermore, it seems fair to assume that the introduction to my project may have differed between clinicians, depending on their understanding of and interest in infant mental health and psychotherapeutic work.

Whilst the impact of this is uncertain, I was mindful that the families would have already have given intimate details of their histories, concerns and difficulties to the assessing clinician, so I made sure that I read the full assessment carefully prior to my first meetings with the families, so they did not feel the need to repeat all of this information again to me.

Five suitable referrals were received during my recruitment period, and all five of the families gave consent for me to contact them, in order to hear more about the project. The families were then given the opportunity to have an introductory discussion, either by telephone or face-to-face. Four of the families attended for a meeting, and one opted for a telephone call. During these conversations, further information was provided, and a full information sheet was given (see appendix iv). I offered the families the opportunity to have some time to think about whether they would like to participate, but all of the families were happy to give consent during this meeting. The one family that opted for a telephone call initially was invited in for a meeting, during which consent was gained. Owing to the recruitment period having taken slightly longer than anticipated, when I had recruited five families, I decided to close the study to any more participants.

It is perhaps important to note that, despite my earlier liaison with the health visitor team, I only received two referrals directly from a health visitor. The recruitment process, especially at the beginning, did take longer than anticipated and I did, in fact, contact one of the health visiting leads, a few months into recruitment, to remind her that the project was open to referrals. Interestingly, she replied, advising that she had reminded her teams of the project, and she stated, '*I thought that you would have had a better response*!'. I think this indicates some of the challenges of setting up a new service or intervention, and how time, patience and on-going liaison with other professionals is needed.

I wrote to each of the children's GP's, following consent being gained, in order to advise that the project was running (see appendix vii). I was not, however, contacted by any of the children's GP's throughout the course of the project, although Harry's mother did consult his GP as the project was drawing to a close (please see postscript chapter for further information about this).

I will now give a brief summary of each of the five families that participated:

Scott Anderson: Scott was referred to our service just before his fourth birthday, by his health visitor. He was initially referred, a few months previously, by a community paediatrician but he was not felt to meet criteria, and so the referral was not taken up by our screening team. It is interesting to note that it was felt that considering Scott's presentation at his age, there was not a need for a specialist mental health intervention. Following this, the health visitor then referred Scott to our service again, sharing her substantial concerns regarding his current presentation.

Scott lived with his mother and younger brother, his parents were separated, following reports of domestic violence perpetrated by his father towards his mother both during the pregnancy with Scott and after his birth. Scott had maintained contact with his father, and there were reports that violence between his parents still continued. By the time he was assessed within our service, his mother had stopped contact between Scott and his father, because of concerns about the impact it was having on Scott.

The referral explained that Scott had been excluded from a nursery, owing to his aggressive and challenging behaviour, and other provisions were unwilling to enrol him because of the potential risks he posed to other children and staff. There were concerns raised about his social skills and his ability to form relationships with others, and reports of him displaying various aggressive behaviours towards others, including hitting, kicking and spitting. Various services were currently involved, offering support primarily to Scott's mother, who was signed off work because of poor health, at the time of referral.

Scott and his mother were offered an assessment with a trainee psychotherapist within the team. They attended with two health visitors, the health visitor who had referred into our service, and another colleague. Following an extended assessment, Scott's family were referred to the project. The first appointment I had with Scott's mother was also attended by the health visitor again.

Harry Tate: Harry was referred when he was four and a half years old. He was referred by his health visitor (who was also Scott's health visitor), and because of her knowledge of the pilot study, she asked directly for him to be considered for the project.

The referral explained that there were concerns regarding Harry's social and emotional development, and a community paediatrician had been involved, although Harry was said not to meet criteria for a neurodevelopmental disorder. It was explained that academically, Harry was doing well, but he struggled to manage relationships at nursery. Concerns had been raised previously regarding Harry's parents' mental health and services had already been involved in order to assess their current parenting capacities.

It was also mentioned that Harry's maternal grandfather had recently passed away suddenly, which had been very difficult for the whole family. His mother had, however, turned down the offer of bereavement support.

Harry lived with his parents and older brother. Both of his parents had a significant history of both mental and physical health difficulties. When Harry's mother attended her initial assessment, she brought along several pages of hand-written notes regarding her current and historical medical history. Harry's parents both worked part-time, although it became clear that his mother moved between jobs regularly.

Harry and family were assessed by a psychotherapist within the team and referred to the pilot.

Amy Hancock: Amy was five years old when she was referred by her school. Amy lived with her parents and an older brother (aged seven). Both children had been adopted when they were under a year old, although neither was aware of this fact.

The referral explained that Amy sometimes exhibited concerning behaviour, including poor risk-assessment, head-banging, and aggression towards others. She was said to show very controlling behaviours at times, and also to struggle with the idea of getting older and growing up.

Interestingly, in the referral, very little information was given about Amy's life prior to her adoption. Amy's parents met with a psychologist for an initial assessment and further information was gained. Amy was born premature, to a drug-dependent mother. She lived with foster carers from birth, but for the first nine months of her life she had regular contact with both of her birth parents. The adoption took a long time to complete, as Amy's birth father contested the decision.

Bella Phillips: Bella had just turned four years old when she was referred to the clinic by a member of staff at the local Children's Centre that Bella and her family attended. Bella lived at home with her parents and her young brother, who was nine months old at the point of referral.

The referral stated that Bella's 'behaviour' was a major concern for her parents, and had been since she was eighteen months old. At pre-school she would hit, punch, bite and spit at others, she would also scream and shout and show little response to adults when they tried to intervene. Particular concerns were raised regarding the levels of aggression directed towards her younger brother, and we were told that Bella could not be left unattended with him, because of fears that she might hurt him.

Bella's father worked long hours four days a week, within the emergency services. As part of his job, he worked away for some periods during the year. Bella's mother was still on maternity leave, following the birth of her second child. They had a close family support network nearby.

Bella was assessed by a trainee psychotherapist, and referred to the pilot project.

Leila Smith: Leila was referred by the GP, when she was four years old. Leila was in kinship care, living with maternal family members, under a special guardianship order. She had moved into their care when she was three, following the experience of severe neglect whilst in the care of her birth mother. Her other siblings were living in alternative provision, and Leila had limited contact with them or her birth mother.

Leila referred to her guardians as ‘Mummy and Daddy’, most of the time, and so during the sessions, and in this write-up, they will be referred to as Leila’s mother and father. They had three of their own birth children, all of whom were older than Leila. Leila’s father worked full time, whilst her mother stayed at home in order to care for Leila and the other children.

The referral explained that Leila’s guardians were having great difficulties managing Leila’s needs, on top of those of their own children. Leila was said to wet or soil herself regularly, and there were great concerns regarding the impact of her early trauma and neglect.

Leila was seen by one of the clinic’s primary mental health workers and referred to the pilot project. In the assessment, it was learnt that Leila showed regressed behaviour much of the time and was having difficulties managing at school.

vi. Analysis

The data gathered (in the form of process notes) from the interviews and therapy sessions was analysed using Thematic Analysis (Braun and Clarke, 2006). I had initially planned to use Grounded Theory (Glaser and Strauss, 1967); however, when it came to the analysis stage, and upon discussion in supervision, I felt that Thematic Analysis might be a more appropriate method. Thematic Analysis can be made use of in qualitative research, and it enables '*identifying, analysing and reporting patterns (themes) within data'* (Braun and Clarke, 2006: 79).

Several authors have written specifically about the process of data analysis and coding qualitative data. Tuckett (2005) gave a detailed description of how thematic analysis can be used within research, making reference to the way in which transcripts can be annotated and coded. Trowell et al (2003) provided an extensive list of codes that had arisen from the data in their research, which gave the reader insight into the wide and varied nature of findings which can emerge from data. These codes would then be grouped and collated into themes.

It was important to me, in this project, that the themes were generated from the data, rather than trying to overlay existing theories or ideas onto the data. This kind of inductive approach was referred to by Brown (2006), who described letting the observation, '*speak for itself and to ensure that theoretic insights follow the observation rather than squeezing the observation itself into ill-fitting psychoanalytic schemas'* (p. 185).

I analysed the data, identifying codes, and then eventually compiled these codes into overarching themes. I was able to compare and contrast these themes in between data sets and identify common themes in terms of the experiences of the families' and the children's experience or focus of the sessions.

I decided to analyse the first, third and fifth therapy sessions from each of the families, with the hope of capturing something of the beginning, middle and end of the treatment. I also hoped these sessions would reflect the trajectory of the therapy. If the scale of this project had been bigger, and if time had allowed, I would have liked to have analysed all of the therapy sessions in detail, but unfortunately, this was not possible. I was, however, able to analyse all of the interview data, using both the pre and post treatment interviews from each of the families.

I will now give a brief summary of the stages I went through in the thematic analysis of the data:

1) The process notes (from the sessions or interviews) were printed in columns, allowing me to read the material on one side of the page, and then write any annotations, thoughts or highlights on the other side (see appendix x). I read through all of the material at least two or three times, making sure that I had noted anything of interest.
2) The next stage was creating ‘mind-maps’ of the areas noted during stage one (see appendix xi). For each session I created a map, including anything I had highlighted or noticed. In doing so, certain ideas came up more than once, or some overlapped or alluded to the same thing. I did, therefore, begin grouping together ideas, where appropriate. These became my initial ‘codes’.
3) I revisited the material from stage two and again grouped together similar or overlapping codes. I then created a sheet for each family, with three columns, one for each session analysed (see appendix xii). In these columns, I listed the codes. I then went through and colour coded these, in order to draw out which were the most prevalent codes across the families. Again, some grouping together was possible.
4) I was then left with the six most prevalent themes, which I went on to explore in detail in the analysis section. Some codes, or initial themes did have to be excluded, due to not being as prevalent or only occurring in some of the families.

In the Appendix x, xi and xii, I have included an example of the analysis which took place at stage one, two and three. I have taken all three examples from one family, in order to make clear the process of development in terms of the generation of codes and themes.

In the Findings chapters, I do at points make reference to data from sessions two and four (which were not fully analysed), because in certain instances information from these sessions was prominent in my thoughts and relevant to the discussion; however, I do try to keep this to a minimum.

vii. Methodological limitations and considerations

Validity and reliability

Vignettes: it is routine practice, within psychoanalytic psychotherapy, to record process notes after sessions, these notes are the therapist's recording of the sessions as a whole, as recalled afterwards. These process notes (and vignettes) go on to be used with supervision, for presentations, for personal reflection and within research and the development of theory and publications.

This method, of recording notes, after a session is one which has been used throughout the history of psychoanalysis and psychotherapy. If we think back to what may be described as some of the key case-study contributions within the field, such as Klein's work with Richard (1961), or Winnicott's, 'The Piggle' (1980) and McDougall's analysis with Sammy (McDougall and Serge, 1989), all of these have made use of clinical vignettes throughout. Interestingly, Klein (1961) referred directly to this method of recording, highlighting both the potential criticisms of this method, as well as the positives.

Klein gave a detailed exploration of this subject, in relation to her work with one patient, which I summarise below:

> *I took fairly extensive notes, but I could of course not always be sure of the sequence, nor quote literally the patient's associations or my interpretations. This difficulty is one of a general nature in reporting on case material. To give verbatim accounts could only be done if the analyst were to take notes during the session; this would disturb the patient considerably and break the unhindered flow of associations, as well as divert the analyst's attention from the course of the analysis. Another possibility of obtaining literal accounts is the use of a recording machine, either visible or hidden –a measure which, in my view, is absolutely against the fundamental principles on which psycho-analysis rest'* (p. 11-12)

This extract captures some of the arguments for and against this method of recording sessions. It is interesting that Klein referred to the option of creating recordings of sessions, as this is something which continues to be discussed today. It has been suggested that creating audio or visual recordings of sessions may provide more reliability (Rustin, 2003). It has been argued that the therapist's written process notes involve a process of selection of two levels, first; 'the *therapist's* selective memory of what took place' and second, '*the author's selective re-editing of the material'* (Midgley, 2006[1]), perhaps suggesting a lack of reliability or validity.

Interestingly, research has taken place in order to explore the possible variation between written process notes and audio recordings. Trowell et al (2003) collected both audio recordings and process notes in their project, and when they compared the two, they found that there were no significant differences between the main themes, the order to events or the transference relationships recorded. Furthermore, Creaser's (2015) research also made comparisons between audio and written recordings, and although differences were found, it was suggested that these did not necessarily compromise reliability or validity. For example, it was found that the written process notes were often much shorter in length than the recordings; however, Creaser explained:

> *This study suggests, however, that such reduction is not automatically a problem, for some summaries do succeed in capturing the emotional tone and key aspects of the interaction, even though other summaries were not able to do this This offers some reassurance when we consider those who have questioned the reliability of process notes* (p. 162)

This is important to hold in mind because, although process notes and vignettes may not provide the reliability of other methods, they do capture something of the writer's experience of the session, which links to the way in which countertransference is used within psychotherapy – something I will say a little more about later. It is recognised that the information gained from process notes can be a useful part of research data, but it does not have to be looked at in isolation, but within the context of other gathered information, such as referral information, contextual information and observations by the therapist (Anderson, 2006).

I will conclude this subsection with a final reference to Midgley's 2006[1] paper. When discussing qualitative data analysis in research, it is suggested that such methods of data analysis can be useful *'within the 'context of discovery''*, in order to *'reach a deeper understanding'* rather than to test a certain hypothesis. This seems particularly relevant in relation to my research project, in which I aimed to learn more about the method of working (which is already used effectively in other settings) rather than to test a hypothesis, as such, or prove/disprove something particularly.

Reflexivity: Brown (2006) referred to how reflexive writing is both an emotional undertaking, as well as an academic exercise. It is this balance between capturing the emotionality and experience of the therapy, with the academic research processes involved, which has taken a lot of time and thinking within this research project. Elliot and colleagues (2012) explored how reflexivity can be made use of within qualitative research, specifically the use of reflexive field notes within supervision. The authors suggested:

> *..writing fieldnotes had a containing function, especially after intense or troubling interviews. They were also a way of accessing the assumptions the researcher was bringing to her analysis, a process of noticing and becoming aware of what otherwise might have been rendered insignificant (*p. 440)

During my project, I wrote down some of my reflections and thoughts in my research journal and throughout this write up I will make reference to some of my notes. I found that by writing down some of my thoughts, pre and post-supervision, I was able to process them differently and it was very interesting for me, as both a researcher and a clinician, to look back at and see how my thoughts and reflections changed and developed throughout the course of the project.

Goals: another aspect of the validity of this study links to the use of goal based outcome measures. These goals rely on the families rating their goals, from 0-10, at the start and end of treatment. Interestingly, within research, families have expressed more concerns about the validity of goal based measures than standardized measures, despite the goals focusing more on the child’s views or aims (Moran et al, 2011). Law and Jacob (2015) highlighted that, although it could be argued that this subjective rating compromises the validity of the measure, it also provides a focus for the therapy from the service user's point of view, and in this way it is a real strength of the measure.

Wolpert and colleagues (2012) conducted research looking into patient-reported outcome measures, comparing idiographic measures (goal-based outcomes) with standardized measures (such as the 'strengths and difficulties' questionnaire). The authors found that both kinds of measure indicated good construct validity, and they concluded that it might be most effective to make use of both an idiographic and a standardized measure within clinical practice. This may have been something I could have considered within my project and perhaps the use of a measure, such as the strengths and difficulties questionnaire, could have added another level of validity and meaning to my outcome measures. However, it has also been noted that there is a lack of specific outcome measures which can be used by younger children and, interestingly, in comparisons made between different age groups, goal based outcomes were more reliably used and monitored in this younger age group than with older children (Jacob et al, 2017)

Experience of Service Questionnaires (ESQ): the statements included in this questionnaire are all positively worded, such as '*I was treated well by the people who have seen my child'*. It is important to consider how this positive wording may affect the answers, as it may be that by presenting the service user with a positive statement, it is more likely that a positive rating will be given.

It has been found that service user feedback very often generates positive feedback from those completing them (Young et al, 1995; Brown et al, 2014). Brown et al (2014) suggested that these positive ratings can be attributed to the service user wanting to please the clinician, or a fear of a negative response from the clinician if the ratings given are not positive. Although generally ESQs are used at the end of treatment, when the service user should, in theory be ready for discharge, in my project they were used at the end of the therapeutic intervention; however, this did not necessarily mean at the point of discharge from the service. It could, therefore, be suggested that the parents' ratings may have been affected by wanting to please me, as the researcher, or by them wanting to remain engaged with the service.

Maintaining the balance of roles

One of the challenges involved in this project for me, was trying to balance being both the clinician and the researcher. Whilst both of these roles felt familiar, individually, trying to 'wear both hats' at once did feel like a struggle at times.

During the project, I wrote the following in my research journal:

> *I have also increasingly found managing the research and the clinical work very difficult. I feel that I need a colleague to help field some of the calls, or help me create end of treatment plans, as it is difficult to manage both the on-going clinical needs of the families as well as the requirement of the research project, such as writing notes, thinking about analysis etc.* (25th September 2018)

During the therapy sessions themselves, I found it quite easy to focus on being the clinician, and I knew that the research elements would happen outside of the session. What was perhaps more difficult were the times outside the sessions, when parents would call and ask for updates or discussions, or when professionals would ask for reports or summaries. At these times, I would find myself pulled, and I can recall longing for a colleague, or a co-parent, to help me with these demands.

Countertransference and psychodynamic research

Central to any discussion regarding research into child psychotherapy is the understanding that whilst psychodynamic academic research has historically been somewhat lacking, there is now an increasing recognition that empirical research into this field is needed, in order to demonstrate effectiveness and reliability of this treatment method (Rustin, 2003). It is, however, acknowledged that bridging the gap between psychoanalytic thinking and therapy and evidence-based research is not necessarily a straight-forward task (Midgley, 2004). Questions have been raised regarding the validity of psychoanalytic interpretation of research data (Midgley, 2006[2]), the reliability of psychoanalytic methodology (such as the use of process notes) and the generalisability of qualitative research, involving only very small samples (Midgley, 2004).

Despite these concerns, there is also recognition that therapy can very helpfully inform research and the development of theory. Rustin (1991) made reference to several tools and skills that therapists have, including observation skills, theoretic knowledge and experience with numerous patients, which could be helpfully applied to the task of conducting research.

Whilst in everyday psychodynamic psychotherapy, we use our countertransference to help us better understand and explore the relationship between patient and therapist, it could be argued that this reflexive and personal method of communication and expression is not compatible with academic research. It has, however, been said that countertransference can be used as a '*research tool'* (Holmes, 2014: 168), and we are reminded that '*Since our subject-matter is in part the emotions, therapists have to be able to feel them in order to be able to think about them'* (Rustin, 2003:141). Holmes

(2014) stated that in order for countertransference to be made use of within research, the researcher will need:

> *a) to be able to observe behavioural and emotional changes in themselves and the participants; (b) not necessarily to accept their own or the participants' words or feelings at face value, but being able to 'feel around' responses and (c) an ability to examine potential links between observed changes in feeling states and other aspects of the research situation, such as changes in participant dialogue* (p. 176)

In my research journal, I wrote some notes about how I was feeling during the project, and I tried to think about how some of these feelings might give me an insight into how the families were feelings.

> *Someone recently referred to a Doctorate as being 'your baby' and this made me think about the challenges of parenting a young child – the uncertainties, the questions, the excitement and the worries. These remind me very much of my project at the moment and I can, at times, find myself feeling quite alone and overwhelmed by my 'research baby', I imagine like the parents involved in the project felt at times.* (5th November 2018)

The use of countertransference allows the therapist to develop deeper levels of understanding of their patients, and what is being communicated within the therapy sessions, which can be used in both the ordinary therapeutic relationships, but also within research too. Rustin (2003) listed several features of psychoanalysis, including countertransference (as well as others, such as the unconscious, projective identification and depressive anxiety), and suggested that these have been identified through clinical work in the therapy room. With this in mind, Rustin referred to the therapy room as the '*primary 'laboratory' in which psychoanalytic research takes place'* (2003:140).

Having summarised the methodology used within this research project, as well as some of the potential limitations of these methods, I shall now go on to look at the findings from this project. The findings will be divided into two chapters; the first exploring the data from the therapeutic interventions; the second looking at the data gathered from the semi-structured interviews and outcome measures.

Findings

Part A – the clinical intervention

The findings from my data have been divided into two chapters, the first explores the data derived from the clinical intervention (the therapy sessions), and the second explores the outcome measure data; that is the information gathered from the interviews, the treatment goals and the Experience of Service questionnaires (ESQ). I shall also refer to my presentations to the staff team and the discussions which followed. I have divided my findings into these two sections because I wanted to give space to explore the data from the clinical intervention and the data from the outcomes measures in their own rights. This separation is likely to link to my own feelings throughout this project, where I had to balance being both a researcher and clinician. At times, it was quite a challenge to manage wearing these two 'hats', which I will say more about later.

This first chapter will be looking at the themes which emerged from the therapeutic sessions. Thematic analysis of the data revealed six main themes; i. 'Who is the patient?', ii. 'My role', iii. 'Physicality – body vs. mind', iv. 'Change and transitions', v. 'Distance vs. proximity – connecting and disconnecting', and vi. 'A wish for more'. Whilst some of these themes were particularly salient to certain families, it is worth noting that all the themes were, in some way, present within a session (or sessions) for all the families. Within the exploration of each theme, I will refer to some or all of the families, as space allows, and I will use clinical vignettes to help explore the themes further.

i. Who is the patient?

This theme relates to how the families viewed the therapy, and who they saw as the focus of the work. In some families, the child was very much seen as the ‘patient’ with a difficulty, which required intervention. For others, the needs of the parents seemed to take over and it was hard to hold on to the child’s needs and presentation. This theme is interesting, in the context of parent-child therapy, because within this work, we try to think of the ‘relationship’ as the patient (Balbernie, 1998), however, this is not always easy. This theme was present in all of the families, although with some it was salient than with others. Of the fifteen therapy sessions analysed, this theme was present in nine.

The first therapy session was of particular interest, because it gave me an insight into how the work was understood by the families, and who they saw as the patient. I recall how Amy’s mother had sat back, allowing me to talk to Amy, and at one point she even apologised for ‘interrupting’, as though she were an observer and not a participant. Harry’s mother referred to Harry knowing that sessions are ‘all about him’, and in later sessions she told Harry’s brother to be quiet, suggesting that the sessions were not for him. With Bella, however, I recorded how her mother and I had sat in silence, watching and observing her play. Some of the parents very much saw the child as the patient, and the focus of my attention, whereas for others there was something more collaborative, and we could watch, think and talk together.

I observed that in some of the families, such as Scott’s, this theme was much more present in the earlier sessions, when it felt very hard to separate out Scott’s needs from his mother’s; however, as the sessions progressed, this theme became less prevalent. I think this represented Scott’s mother’s growing ability to think about Scott, and his experiences and communications, and the relationship between them, without her own feelings and thoughts intruding in what appeared, at times, to be an overbearing way. For Amy's, Bella's and Leila's families, this theme became more apparent as the sessions went on and it became increasingly clear that the presenting difficulties in the child were closely linked to difficulties in the parents, or the family as a whole.

One of my observations, from this project in general, was the high level of inter-professional liaison which took place. I experienced that a lot of the discussions with the network (occurring outside of the therapy) focused on the parents' needs, not only the child's, and at times it did feel quite unclear as to who the patient was and where the focus really lay.

In session one, Scott and his mother arrived thirty-five minutes early, which became a pattern in the following appointments. Whilst I set up the room, I received a call from the health visitor, who had referred Scott. This conversation, which lasted thirty minutes, focused predominantly on Scott's mother's needs, including how much support she had received previously, and how she can appear to take a long time to absorb information. The health visitor informed me that she has observed Scott's behaviour escalating, and becoming more demanding and physical, when his mother collects him from nursery. I was given a lot of information, even before I had begun the clinical intervention, about Scott's mother's needs and difficulties, as well as how Scott's behaviour and communication differed around his mother.

It became clear that whilst Scott's mother had received lots of support, from various professionals, including nursery, health visitors and family support, much of this support was focused on her own needs. In our sessions, I experienced Scott's mother often trying to talk to me about something, in a somewhat unremitting way, even when Scott was doing something which required immediate attention from us, as the adults, such as escaping from the room, or damaging equipment.

The following extract comes from session three. Scott had left the room suddenly, running down the corridor towards the water dispenser.

> *Scott's mother seemed to slow down (inside the room) and said, "There was something I needed to ask you". I suggested that we go into the corridor so we could see Scott. She did not reply, but went on to ask what she should do if Scott won't see his father (referring to the Court's involvement). Scott was now filling up a cup of water and I felt an urgency to get to him and monitor this. I felt a familiar feeling of Mother desperately wanting my attention, whilst Scott was left to fend for himself. I said that I would call her later to discuss this and she agreed, thanking me.*
>
> *When we reached Scott, he was sipping from a very full cup. He then tried to pull the 'drip tray' from the machine but it was full, so as he pulled, it emptied all over the floor, creating a large pool of water. Mother immediately said, "Don't worry, that wasn't your fault", and I suggested that Scott might need a hand with his water. Mother then continued trying to talk to me about Court and I again repeated that I would call her later'.*

It was clear that in this moment, Scott's mother's own needs, in terms of how she would manage contact with Scott's father, and the Court's involvement, took the central focus in her mind, which left Scott on his own. Scott's rush to get water, which ended up over-flowing and spilling out onto the floor seemed to reflect his mother's state, in which she found it hard to contain her own needs, and seemed to 'over-flow' into the session. I found myself spending additional time (outside the allocated therapy time) mopping up the water, and making additional telephone calls to Scott's mother and the network. It seemed that both Scott and his mother required a lot of input in order for something to feel absorbed and contained.

In the other families, the parents presented lists of difficulties that their children were experiencing, including showing aggression, being controlling, having toileting difficulties, or having particular sensory needs. Harry's parents arrived with a clear view that their son was autistic and required a diagnosis. I was told by Harry's mother that she was certain that a diagnosis would be given and she felt that my intervention was the next step to achieving this. In each session, Harry's parents would tell me about the difficulties Harry experienced, and these were often introduced as "another problem he has". In session three, Harry's mother returned to this topic:

> *She said that there has always been something different about him, "..but that's just Harry". She said that they are trying to work out what it is, or what they can do. I said that it was clear that they really wanted an answer or a diagnosis, and I wondered if this might link to a worry about something being missed or overlooked. I reflected that in their own lives they might have experienced having had to wait, or something being missed, and this might impact on how they are approaching Harry's needs now. Mother stared at me, silently, before saying "I guess so". She went on to mention some significant trauma that she had experienced earlier in her life.*

It seemed that Harry's parents' needs and experiences were becoming enmeshed with Harry's, and his parents were so focused on him receiving a diagnosis, that it seemed that almost every behaviour or communication he made was explained by him having a neuro-developmental disorder – despite most of these appearing to me as being quite ordinary for a boy of his age. I recall that Mother had returned to the following session and was cross with me, she said that she had spoken to her mother and they agreed that there was definitely something "wrong" with Harry requiring "specialist support", and it was nothing to do with her or Harry's father's experiences.

Although these interactions with Harry's mother clearly identified Harry as being the patient, it is interesting to consider how Harry's parents' pathology may have been contributing to this view. It was at times a struggle for me to maintain my position, I felt that I was being invited to collude with an idea that the difficulties lay solely with Harry. It seemed there was little space to consider how his presentation might be linked to his parents' mental and physical health and the impact this has had on his life experiences and their relationship.

Parental physical and mental health clearly has an impact on a child's development, functioning and relationships, and so with any work involving parents and children together, it is of course always necessary to work with what the child presents with and how this might be linked to the parents. Fraiberg and colleagues (1975) described how, in parent-infant psychotherapy, there is a movement back and forth between child and parent(s). As this theme suggests, it was, however, sometimes a challenge to balance this moving back and forth and as the sessions progressed, it became increasingly evident, in some of the families, that in order for the child's current situation to change, the parent(s) would need to access some support of their own.

Bella was referred regarding the high levels of aggression she was exhibiting at home (primarily towards her younger sibling) and at pre-school. The referrer told me that they were a "nice family" and Bella's presentation was, therefore, greatly puzzling to those around her. Without going into the interview data too much, I was told by Bella's mother in our first meeting that Bella's father can become easily frustrated and will sometimes smack her. Now, whilst this did not come up in the clinical work directly, it was certainly present in the background and in my mind. From telephone conversations I had with Bella's mother between sessions, and some brief passing comments made during sessions, it became apparent that Bella's father's levels of aggression and anger were almost certainly contributing to Bella's presentation.

In session three, when Bella's father was not present, I asked Mother how they, as parents communicate their feelings.

> *She said, "I haven't really thought about it before!", but looked interested as she considered this. She said that she tends to keep it inside, until it gets too much and then eventually she might shout, whilst Father is much more like Bella – they have very little patience and become easily angered and frustrated. I commented on the initial meeting and some of our thoughts about the similarities between Bella and her father. I reflected on Mother's comments that she needs to keep everything together, and she said that she knows she cannot be like Bella and Father, so she keeps it all in. Mother said that Bella had been with her Grandma once and done something she shouldn't have, and when Grandma talked to Bella about this, Bella asked her why she was not shouting like Mummy or smacking her like Daddy.*

It became clear how Bella's behaviour very often mirrored her father's (and, at times, her mother's), and as the sessions progressed, I found myself thinking more about Bella's father's mental health, and I think it would have been quite easy to become very preoccupied with this. It was interesting for me to observe how Bella seemed to have an understanding about who the patient was and why the family attended the sessions. In session five, Bella had been reading a book with her parents.

> *Bella began telling me not to talk, and said to her parents, in a rather demanding tone, "You talk to her". I said that Bella wanted the grownups to talk, but she replied, "No, you listen, they will talk". Bella's father said that she had not really wanted to come today, and had been reluctant to get out of the car. I said that it can be hard for Bella to come in the room, because this is a room where we've talked about a lot of tricky things.*
>
> *Bella told me again to stop talking and that her parents would talk, so I said that Bella had a clear idea that her mother and father needed to tell me things, and that I would listen. When I asked what they should talk to me about, she said "Me and Chester". I smiled, as did Mother and Father, and I said that I thought she had a good idea about why we were all here today. Mother commented that she had never really told Bella why they come here, just that they were coming to see someone called (the therapist). I said that I thought Bella had a good understanding, and mentioned that she will have heard our conversations and noticed how we are here to think about her and Chester and the family. Mother nodded and said that Bella does tune in to everything, even when she looks otherwise distracted.*

It was as though, in that moment, Bella was trying to find a way to remind us that we were together to think about her (and her brother). She was clearly expressing that it was her parents who needed to engage with me, but that she and her brother needed to remain the focus of these discussions. She had an idea that I would be the listening therapist and her parents would do the talking. This leads me on to the next theme, which also was present in many of the sessions, and that was ‘My role’.

In summary, this theme has explored how the varying needs and wishes of the different family members were communicated, understood and worked with during the therapy. It was sometimes a struggle to keep in mind that in parent-child work we are trying to focus on the relationships between the family members, and how the parental states, experiences and feelings impact on the child. In brief work, this ability to remain focused seems even more salient.

I have wondered if the children involved had been younger (perhaps babies or infants) whether the parents might have been more open to thinking about the relationship between them and the child. It seemed that because the recruited children were older, with (to an extent) their own independence, personalities and wishes, some parents appeared to want to abdicate their responsibilities, in terms of engagement. Some expressed a wish for the child to be seen and responded to individually, rather than as part of a parent-child dyad or triad.

It may be that because this work was carried out within a CAMHS clinic there was an expectation (despite the information given at the start) that we would meet to think about only the child, and I think for some of the parents, the idea of thinking about themselves and their own experiences and ways of relating, was anxiety-provoking and daunting. It appears to me that this kind of work requires a fine balance. The child needs to be seen as the central focus of the work; however, they cannot be seen in isolation.

ii. My role

During psychotherapy sessions we, the therapists, often find ourselves thinking about our role, so perhaps it is unsurprising that this came to be one of the themes from the clinical work. It was, in fact, overtly present in thirteen of the fifteen sessions. This theme refers to how I, as the therapist, was viewed, both in terms of what the expectations of me were, but also how my presence and relationship to the children, and parents, was understood and responded to.

During the project, I often found myself reflecting on the question, ‘What is my role?’, which I think links to several factors. First, as mentioned in the previous theme, there was sometimes a struggle to identify who the patient was, and this created difficulties for me as I experienced moving between feeling like a parent-child therapist, to an adult-therapist, to even a family-therapist. Second, this theme links to my role within the network where there was a high level of liaison, so at times my role appeared to be to gather and share information. Third, I think this theme also links to my dual-role within this project – clinician and researcher. This was particularly difficult at the end, when my clinical intervention was complete, but it was clear that the families required some further intervention, beyond the scope of the project.

Finally, the idea of roles might also have been present because of the nature of this project, working with young children and (relatively) new parents. A lot of the topics discussed centred around the child’s behaviour, often linking to their frustrations and wish for control, or their changing capabilities and needs. We often spent time thinking about this particular stage of the child’s development – all of the children involved were either four or five years old, and a lot of the parents’ reports of their children were very similar. The children were developing a new sense of identity, no longer infants solely reliant on their parents, but entering a new phase of their development. The parents themselves were discovering new facets of their role, including parenting an older child, a child who is mobile, can talk, perhaps attends pre-school or nursery and often has a very clear idea of what he/she wants! The theme of ‘roles’ was, therefore, salient within this research for a variety of reasons.

I will now mention how this theme emerged during my work with Leila and her family. As mentioned previously, Leila was a ‘looked after child’, and Mr and Mrs Smith were her special guardians, although generally she referred to them as ‘mummy and daddy’. Therefore, roles and identities could be said to have had particular importance for Leila’s family, which was reflected in the clinical sessions.

At some point during each session, Leila either requested a drink of water or said she needed the toilet. What became quickly apparent was that I was left to supervise these trips and offer help. In the first session, when Leila said that she needed a drink, and went to leave the room, her mother remained sitting, leaving me to escort her. Later, in the same session, Leila needed the toilet:

> *Leila went to the door, and said she would go on her own. I reminded her that someone would need to go with her, and interestingly, Mother remained sitting, so I followed Leila out of the room. I waited outside the toilet, and when Leila finished and left the toilet, I found myself reminding her to flush the toilet and wash her hands, as she had done neither.*

I found myself moving into a parental role, not only accompanying her to the toilet, but also reminding her to flush the toilet and clean her hands, which I would not necessarily do with the other children. It was interesting for me to note how I moved into this role, and how Mother, with her lack of action, momentarily distanced herself from the role of being parent. This interaction during the session may well have reflected something of Leila and her mother's relationship at home. Leila may have experienced her mother being available and 'maternal' at times, whilst at other times, she may have appeared more distant and unavailable.

In other sessions, Leila showed a recurring interest in my photograph on my work badge. In one session, she pointed at it, asking why I was not smiling, and then in the following two sessions she mentioned my absent smile again. In the final session, Leila found a pack of stickers and selected one for me, a tiny smiling face. I had at first felt puzzled by her interest in my badge, but in session five, I came to understand that this interest was linked to her interest in me, what kind of a person I was - a still-faced therapist, or someone who could be smiley and warm, perhaps even maternal. It became clear that my photo worried her and she worked hard throughout the sessions to engage me, and to perhaps elicit a smile, including by bringing me edible treats, and artwork.

I believe this may link to Leila's experience of being a looked after child, who has experienced, on some level, a rejection from her mother. Leila may have been quite anxious about what kind of adult I would be, and, therefore, she worked hard to try and placate me. A smile could be seen to represent a level of warmth, and it may be that Leila searched for this, in order to feel actively welcomed and wanted. My smile's absence may have linked to a fear that I would reject her, or turn her away, something which would have felt very frightening for Leila.

I think Leila's interest in me and my role linked very much to her experiences in her life. It was also interesting to observe that it was not just my role on Leila's mind, but also Mother's. Generally, Leila referred to Mrs Smith as 'mummy'. In the first session, however, we saw clearly the level of muddle in Leila's mind about this:

> *As we continued to play a throwing game, Leila said the object goes from "(the therapist) to mummy" she paused before saying Mrs Smith's first name, before then saying "my aunty". She looked unsure, which was interesting (and painful), as she had been referring to Mrs Smith as 'mummy' previously; however, in that moment she seemed confused about this and indeed what or who Mrs Smith was to her.*

Mother talked to me at other points about how Leila moves in-between the different names, and sometimes the use of Aunty or Mrs Smith's first name linked to times when Leila was feeling particularly unsettled or agitated – perhaps as was the case during the first session. I observed also how Mrs Smith moved between being very attentive, warm and maternal towards Leila, to at other times seeming somewhat removed, such as when Leila needed the toilet.

Another part of this theme was how the parents helped their children to understand my role and their visits to see me. In my initial conversations with parents, I had suggested that they might talk to their children about coming to talk and play with me and how we might think about how things are going and how everybody is feeling at the moment. It was interesting that most of the parents decided not to talk to their children very much about coming. Amy's mother, however, chose to tell Amy that they were going to visit a friend and introduced me to Amy as "mummy's friend".

Later in the session, Amy asked me directly, "Are you Mummy's friend?". I felt that it was important for me to try and be honest and open with Amy, but I was also aware that Mother had explicitly told me that she would only refer to me as her friend, because she did not want to upset Amy, or for Amy to refuse to come and see a professional. I decided to tell Amy that I had met her mother twice before, and I went on to talk about me and Amy getting to know each other, and linked it to her recent play, which had centred around friends.

It seemed very hard for Amy's mother to talk to her honestly about my role, or why they were attending the sessions. I found myself feeling somewhat silenced at times, unable to talk openly and often being asked to speak with Mother by telephone, separately. The dynamic within the sessions with Amy's family, I think, mirrored the situation at home, some things were not spoken about freely, and there was an ever-present feeling of something being concealed. It seemed that Amy was aware of this, and her direct question to me about whether I was her mother's friend reflected that she understood something more about my role.

It seemed that some of the families viewed me as being quite powerful, and I was seen as being the 'gate-keeper' to further support, or diagnoses. At times, frustration was expressed about my intervention, and some of the families felt that I had not solved the problem or had, in some way, missed something.

With some of the families, there was, as the sessions progressed, a sense that I did not 'get' the difficulties, or did not 'see' everything. For example, at the end of Amy's first session her mother had said that I had only seen "best behaviour"; and when Amy's father attended for the first time (session three), he commented that it was "the quietest I've ever seen her".

Harry's parents also had commented on how Harry (and his brother) were behaving unusually in the sessions, and in the final session, Mother quickly brought this to our attention once again:

> *Once inside the room, we took our seats, as Mother said, "I hope they're not on best behaviour today". She went on to say that she had told them not to be, because "all you're seeing is best behaviour, they're never like this usually". I suggested that she might feel I am missing something, not seeing the full picture. She did not really reply.*

The beginning of the session was, unusually, loud and unsettled, with the boys moving the furniture, arguing and laughing in a somewhat manic way when told to stop. However, as the session went on, this changed, and they were able to settle into some play, both on their own and with Mother and me.

> *I mentioned how the boys had settled very much since the beginning and how they were now both engaged in their activity, in what appeared to be a calm and focused way. Mother said that she had said to them at the start that they should not be on best behaviour here, which might have contributed to how they were at the beginning. I said that I was aware that coming to the clinic was a different environment and, therefore, they may not behave in a 'typical' way whilst here. I said that I was interested in learning about their relationship and how things are during sessions, but also, of course, thinking about what I hear from the parents and the boys about things at home and other places.*

There appeared to be an idea, in Amy and Harry's families particularly, that I was not seeing everything that I should be, and that by their children showing me their "best behaviour", I would not really understand the difficulties. I also thought, at times, that there was a wish for me to see and have to deal with the 'worst behaviour' as the parents felt that they had to do much of the time. All of the parents were seeking help because things were difficult and challenging within the family and they were under a great deal of strain. I think their wish for me to see everything, or a fear that I would not understand, was linked to the wish for help and support, in order for things to change and feel better.

Harry’s family asked on several occasions for strategies or techniques and when I was unable to give these, they seemed disappointed and frustrated. The following vignette comes from session three:

> *Mother then asked if I had thought of any techniques for them to try. I said I thought it would be helpful for us to continue to think about what they are seeing now in Harry, but also their early memories and experiences of being with Harry. Mother said they had tried staying with him until he falls asleep and with a somewhat dismissive laugh she added, “We’ve tried everything”. I said that I understood they had tried a lot and really want to find some other way of doing things, but I was just reflecting on what I had observed today – how soothed Harry is by touch. Mother said, in a tone which appeared a little disgruntled, “Well, we can try it again”. As I continued talking, she took something from her bag and I soon realised it was a large stack of post-it notes and she was writing down what I had said.*

Harry’s mother’s need to concretely record my advice reminded me of how she had previously brought in notes from conversations with Harry’s nursery manager, who was said to be their “guru” and an “expert in children”. It was interesting for me to notice the splitting that took place, and how the nursery manager was viewed as the expert, whilst I was seen as somewhat unhelpful, or perhaps even useless.

Some of the families talked of having waited a long time for support, and how pleased they were to be listened to, finally. This wait, I think, also contributed to a high level of expectation, and so the time-limited nature of the pilot perhaps felt frustrating for some of the families.

I will end this section with a vignette from my last therapy session with Amy and her Mother. During the course of the sessions, we had spent time thinking about both of the parents' expectations of Amy, particularly in relation to her eating and being 'naughty'. Amy's parents had quite fixed views about the ways their children should or should not behave, and Amy was described as 'choosing to kick off'. In the final session, Mother and Amy attended on their own:

> *Mother then began to talk about her trying a bit of a different approach with Amy recently, following having watched a video about infants and feeding. She referred to Amy's brother having had sensory issues regarding food, and how they had to go quite slowly in terms of introducing different textures and flavours. She added that Amy does not struggle with things in the same way, but meal time can still be quite difficult, in other ways. Mother said that in the video, the woman had suggested not looking at the child's intake over a day, but rather over a week, in order to take the pressure off the particular meal time… … I said that it sounded like they had been thinking a lot and trying some new approaches quite recently… she agreed and said that it all stemmed from watching the video about food, and her thinking about not putting so much emphasis or focus on the negative behaviours.*

Amy's mother seemed to be clearly letting me know that any shifts in her relationship with or approaches to Amy were to do with the video, and not the sessions. I noticed, within my counter-transference, that I felt somewhat annoyed by this, and found myself wanting to tell Mother that these were things we had been talking about here for the last four weeks! However, I think the timing of these comments also linked to our ending and how perhaps Amy's mother needed to locate the source of help in the video, and not in me, because my therapeutic involvement was ending. It could also be suggested that in this final session, Amy's mother was able to gather something up from the sessions as a whole. Perhaps each individual session had not felt satisfactory or 'enough', but by the end, something had been taken in, which allowed a sense of positivity and potential for change.

My role and intervention for the families was time limited and I think this was difficult for some of them. I will go on to say a bit more about the significance of the ending session in a later theme 'A wish for more', but now I will move on to explore another theme (which also links to endings) and that is the impact of change and transitions.

This theme has captured some of the different dimensions to my role, during this project. I found myself having to be quite adaptable during the work, and it was not always easy to maintain the role of both clinician and researcher. It was clear the different families each approached the sessions in a different way, each with their own individual expectations, hopes and wants from me and the work.

iii. Change and transitions

This theme links mainly to the idea that change and transitions were found to be very difficult for most of the children involved in the project. I was told by the parents, in different ways and at different times, that their children often struggled with change and, therefore, routine and consistency was said to be very important for many of the families. The therapy sessions themselves provided several changes for the children, including attending a new place, meeting a new adult, and the general beginnings and endings involved in all therapeutic work. It was interesting to see how the different children (and families) managed these; for example, did the child feel comfortable coming to the room, did the child try to leave the room during the sessions, and how did they manage when it was time to finish a session? All of these were things I tried to observe and reflect on during the sessions.

The theme of change and transitions occurred in eight of the fifteen therapy sessions, mainly in terms of the parents mentioning the significance of change to their children. The parents of all the children mentioned, in one or more sessions, either how their children struggled to manage or tolerate change, or how routine and structure were important.

Change also seemed an important topic because the purpose of all of the sessions was, in some way, related to change – whether that be in terms of wanting to change the current situation, or the parents having noticed a change in themselves or their children, or there being some struggle to adapt to a change. It could be said that by giving consent and opting to engage in the therapy, the families were all hopeful that things could change and develop - although often that was not an easy or straightforward process.

One way we might think about change, especially external changes, is a link to a reduction of control. When things around us are changing, we can feel destabilised and unsettled and this can lead to a wish to gain back some control. It has been suggested that children who experience a loss (or trauma) during early childhood can go on to show a need for omnipotent control later in their childhood (Barrows, 1996). Furthermore, we also know that an increasing sense of agency and independence, and a wish for control, is typically associated with children of this age group.

I will now say a little about how this theme emerged within my work with Bella and her family. As previously mentioned, it was reported that Bella's difficulties seemed to begin quite suddenly. When Bella's mother and I spent some time trying to 'track' this back, we found that the shift in her behaviour seemed to have coincided with the birth of her younger cousin. What emerged was that Bella had been the only child (daughter, niece, and granddaughter) in the family until her cousin was born; and, at almost exactly the time of his birth, Mother fell pregnant with Chester. She subsequently became unwell during the pregnancy, meaning she was less physically available.

It seemed that these changes and the associated loss of her position as the 'baby of the family' was troubling for Bella and, in response her levels of violence and aggression quickly increased, in particular towards babies and younger children. Bella had been the only child, and the sole focus of both of her parents and wider family, but then she became one of three (and subsequently more cousins were born) and this change was hard for her manage. I heard that during family parties and get-togethers, Bella would usually end up showing physical aggression towards one of the other children, or her mother.

I was also aware that Bella had experienced several hospitalisations and painful medical procedures during early infancy, which were likely adding to her current difficulties in terms of undigested trauma. Whilst this topic did not feature during the sessions themselves, these early experiences were, no doubt, very significant for Bella (and her parents), in terms of the acute pain suffered, and the associated separation from her parents and intervention from medical professionals.

Furthermore, it was also important to consider that Bella's father had always worked away at times, and during these periods I was told that he did not usually have contact with her, "unless she's been naughty". There was, therefore, a sense of lots of change within Bella's environment, as well as in her father's own mental states and how he responded to Bella.

It was also interesting for me to note how quickly things seemed to change during the sessions, and I was often left feeling confused and puzzled by how rapidly the mood shifted. The following extract comes from session three, which only Bella and her mother attended. During this part of the session, they were reading a book together:

> *Bella began to turn the pages more erratically, so Mother could not finish reading and she then began to utter words herself. This was, I thought, the first time I had heard her 'language'* during this session. Bella giggled and continued to say the words, and I asked Mother if she thought these were words or the tune of another Dr Seuss book (there was something poetic about the way Bella was speaking). Mother said she did not know and asked Bella if it was a song or a story, but Bella did not reply, other than saying that she wanted to read. Mother agreed and Bella began to try and speak, but she seemed to suddenly become very frustrated and quickly let out a very loud scream before hurling the book away. She then ran from the sofa herself, lying on the other one. When I looked at her face I was surprised to see she was now smiling.*
>
> *I questioned, "I wonder what just happened then, Bella was looking at the book with us and then suddenly there was a loud shout, the book was thrown and Bella left". I asked Mother if she thought it was linked to some frustration around trying to read the words, and she nodded and said she thought that it probably*

> *was. She said that Bella becomes quickly very frustrated and cross when she cannot work something…*
>
> *…Later, during the play, Bella seemed very engaged and playful but then she seemed to move quickly into frustrated states, appearing to be trapped behind chairs (although in reality she was free to move) or becoming cross with the dolls or us. At one point in the midst of one of these 'rages', she suddenly picked up the pen pot and began to pick at the label. When I commented on this, she just dropped it on the floor, and then a moment later she swung her arm round and caught the edge of my neck with her arm. Afterwards, I thought to myself about the sequence and how quickly she moved between feelings and engagement with things, as there were no transitions or processes but just one to the other, and potentially back again. I think my feelings towards her reflected this and I found myself feeling very warmly towards her and wanting to play with her and engage, to then suddenly feeling very distant from her, and I found myself wondering if she might try to hit me or leave the room at any moment.*

*During the earlier sessions, Bella had spoken in what appeared to be a made-up language. Mother said that Bella had developed this language herself and uses it quite frequently at home.

Bella seemed to move quickly between different feeling states and I was surprised by her quick transitions between rage and upset, to smiles and laughter. I found myself feeling unsure at the start of sessions, wondering what mood she would be in, or indeed whether she would come to the room (as in several sessions she initially refused) or remain in the room throughout the appointment. I wondered how much my feelings of uncertainty reflected Bella's own feelings, and I think she was clearly giving me an experience of what it is like to be with someone who is unpredictable and changeable, which I came to understand mirrored something of her experience of being with her father. I heard that at times, especially going swimming and at bedtimes, Bella and Father had a very warm and close relationship, as I had seen during the sessions; however, I was also told that his moods could quickly change, and he could become easily frustrated or angry and would at times smack Bella, or leave for work without kissing her goodbye.

I think this left Bella often in a heightened state, in which her own mood and behaviour could quickly change, but also in which she was very aware of change within her environment. For example, Bella paid close attention to any damage within the room, and during one session she took a stethoscope and pressed it to a piece of chipped plaster on the wall. I noted the following in another session:

> *Bella was now colouring quietly with her father, who was praising her careful colouring within the lines. Suddenly, a little gust of wind came through the open window which made the door rattle. It was a very quiet noise but Bella immediately looked round. I said that she had heard the noise of the wind, but before I could finish, she had run from the room laughing. Father raced after her and I asked Mother if she too thought Bella had heard the noise, she nodded, commenting on how subtle it had been.*

This change in her environment led to a sudden physical change in Bella, and a need to escape from the room. I think, despite the laughter, Bella was concerned by the noise and she responded with physical action. I will think more about the role of physicality and physical expression in a later theme.

Change was also particularly present in the work with Leila. Leila, as previously mentioned, had experienced a great deal of change during her life, and even though her current situation was relatively stable, the future was not certain.

Within usual practice, one would try to offer sessions in the same room, at the same time, on the same day, where possible, although of course the constraints of the families' commitments, clinician's diaries and room booking systems are all a reality. It was, however, curious that whilst for most of the families there were perhaps one or two slight changes, for Leila the five sessions took place in three different rooms, on several different days and at different times. This was in part because of the family's availability, which limited the rooms I could book, and the fact she was my last research family, so my availability was somewhat compromised; however, it was apparent to me that this experience of change and inconsistency also mirrored some of her experiences in her life so far.

Despite my attempts to prepare her as much as possible, Leila was, unsurprisingly, very aware of these changes and would often ask why we were in a different room, or which room we would be in next time. This theme of change extended beyond the physical arrangements of the sessions, and was evident within the content itself. I will now refer to an extract from our first therapy session:

> *Leila said that she needed a drink, so I said that we could go quickly and get a cup of water from the water dispenser. Interestingly, Mother did not move, but Leila was quite happy to come with me on her own. As we went, Leila said that mummy "might play with the dolls", but I suggested that I thought she might wait for us.*

> *When we returned, Leila quickly looked into the doll's house and exclaimed that everything had been moved. I felt unsure, as I had not checked the layout before we had left. I was confused, wondering whether her mother would have done this in our absence. Mother, with a straight-face, replied, "It was the fairies" and Leila stopped in her tracks and looked at her. Mother said that the fairies had come in and tidied up the house, because Leila is so "beautiful" that they wanted it to be all nice and ready for her.*
>
> *Leila asked where the fairies were now and then pointed at the lights and whispered "Are they in the circles?", but Mother said that we couldn't see them now. Leila puzzled over this, thinking for a few seconds, before saying that Mother was tricking her. There was a bit more back and forth between them, before Mother eventually exclaimed, "You got me – you're right! I was being a silly, naughty Mummy, wasn't I?". Leila giggled and looked quickly at the doll's house again.*

It seemed that unexpected change appeared in all areas of Leila's life and, although Mother's rearranging of the house had a playful quality to it, it also felt painful as it seemed to capture something of Leila's experience of unanswered questions and sudden changes, having gone from living with her birth mother, to then moving to a completely different house and area, with new adults. The notion of fairies may have also been quite unsettling for Leila, a little girl who had experienced so many confusing and inexplicable things during her life. It seemed as though firmer, more comprehensible, 'ground' would have helped to make Leila feel safer.

I heard from Leila's mother and school that Leila particularly struggled at the transition points of the school day, such as arriving in the morning or returning to the classroom after break. Interestingly, this was also the case for most of the other children too. Moments of change, or transition were hard to manage, and it was, therefore, perhaps unsurprising that the beginning and ending of the therapy sessions were also sometimes challenging. I will conclude this theme by referring to the last of the five therapy sessions, which was effectively my goodbye with the children.

I will do this by giving a brief extract from the endings with each of the children:

Scott: *I said that I would call Scott's mother, and then tried to say goodbye to Scott, again reiterating that it is was our last session. Scott asked "why" but was meanwhile trying to get out the main clinic doors. There was a sense of something chaotic, and out of control, with no goodbye shared between Scott and me.*

Harry: *we left the room, with me confirming that I would see Harry's mother in two weeks (for the review). Mother commented on her bag being so uncomfortable, and how all of her other bags were soaking wet, because of the boys' leaking water bottles. Again an idea of containment, or the lack of, came to mind. The boys ran ahead to the doors, and muttered a brief goodbye as their mother chased after them, shouting at them to hold her hands and slow down.*

Amy: *I said to Amy that I would speak to her mother soon and find out how everyone was getting along. I said to her mother that I would be in touch to arrange a review and she nodded, but looked hesitant and somewhat expectant. As I said goodbye, Mother said, "So do you feel all positive things now?", which left me momentarily silenced and unsure of what to say. I said that we could think more in our review meeting and I would be in touch. Amy said goodbye and her mother thanked me and walked out, leaving me still feeling perplexed by her final comment.*

Bella: *Bella's parents encouraged her along, with her father suggesting that they could hold hands. She refused, so he said that she must walk with him and she said "I will", but as he let go, she sprinted up the corridor. I confirmed the plan with Bella's mother, regarding arranging a review and me speaking to school. She said again "I think that would be really helpful". At the doors, I said goodbye, and Father said, "Say bye now", but Bella ignored me. Her parents prompted her again and she said "Bye" but whilst drinking water so the cup filled her mouth.*

Both parents said goodbye and they walked off. This ending felt unsatisfactory and difficult – it seemed that these feelings were shared by us all.

Leila: *Leila tried to leave the room then, but her mother asked her to wait for a moment, which she did. Mother said to Leila, "it's time to say goodbye now, this is the end of our sessions together", but Leila did not reply. I said that I had enjoyed getting to know them and spending some time together. Mother said, "Thank you very much for everything". Leila did not reply, but ran ahead down the corridor. At the doors, I said goodbye, and Mother thanked me again and said goodbye, whilst Leila rushed to the outside doors, ready to leave. I felt a bit saddened when she did not turn round to say goodbye and I thought about this as another ending for her.*

I included these extracts because I hoped to demonstrate how the endings (and the change to our routine of meeting) were difficult, both for the families, and also for me. The last sessions seemed, generally, to include loud and uncontained behaviour in the children (often reminiscent of first sessions), disappointment and frustration in the parents, or, in Amy's mother's case, a wish to end on a 'positive' note. I noticed how some of the children were unable to say goodbye to me, despite having done so in other sessions, and this might have been because it was the last time we would meet, and, it was, therefore, as Harry’s older brother described, “Goodbye for ever and ever”.

The impact of change came to be quite a central theme during the sessions, in terms of how change was responded to and understood during the therapy, but also how for the children there had been significant changes in their early history, which had had a lasting impact on them, in different ways. For two of the children this meant the huge change of leaving their birth families, whilst for others the changes included parental separation, changes in accommodation and the birth of siblings. Whilst these kinds of changes may not be uncommon within a family’s experience, it seemed that for these particular families these changes had been hard to process, or had led to some kind of significant shift in the functioning and wellbeing, of the child or their parents.

I shall now move onto my next theme, the way in which physical expression featured within the sessions.

iv. Physicality - mind vs. body

This theme captures how physicality was expressed by the participants, particularly the children. Physical expression was understood in different ways, at times being seen as a problem (for example, in relation to physical aggression), whilst at other times being seen as a strength or a sign of capability. Part of my role was to help the families think about the way in which physicality was used and what this might communicate, in relation to both challenging behaviours, but also in physical expression through play.

The referrals received for all five children mentioned the child displaying high levels of aggression or violence, either within the home or at their education setting. This physical expression was of concern to the adults involved and it seemed to be one of the main areas that the parents wanted support with. Canham (2004) referred to a gang-like state of mind children can find themselves in, which was described as ‘anti-life, anti-parents, anti-thinking’ (2002:115). This idea of ‘anti-thinking’ is important because I think, within the families, there was sometimes a difficulty in thinking, so the children developed ways of physically expressing their feelings, in often forcible and aggressive ways.

Whilst this theme could just refer to physicality in terms of aggression or violence, I shall be exploring it in terms of how physical expression was used, I think, as a means of communication by the children. I will refer to how the children (and families) expressed themselves physically, which at times seemed to prevent space for thinking, or talking – this is the concept of ‘mind vs. body’, as mentioned in the theme title. I believe that one part of this work, for all the families, was to help them ‘think’, with a hope that there could be space created to use the mind rather than just the body.

This theme occurred in thirteen of the fifteen sessions; in some cases, this meant children displaying physical aggression within the sessions, while in others, the parents described such behaviour occurring outside of the therapy.

I shall begin by sharing a few thoughts from my work with Harry’s family. For Harry, physicality and the use of his body was referred to as both a great cause for concern, but also a strength. Harry’s mother told me in several of the sessions how Harry was “very good physically”, and shows great strength and physical dexterity, as did his brother, Reece. However, alongside this, Harry’s parents shared their worries that he had “global delay”, or Autism, giving examples of his physical difficulties, such as regularly smearing his faeces and head-banging at bedtimes.

As mentioned earlier, Harry's mother came to the sessions wanting either practical techniques or strategies, or for me to refer them on for a diagnosis. It seemed that she wanted a physical response from me to her reports of physical difficulties in Harry. It appeared that often Harry's communications were interpreted by his parents as him being troublesome or having some kind of neurological difficulty. I felt that it was my job to try and explore these ideas with them, with a hope that we might be able to think a little about what else might be behind these behaviours or what Harry might be trying to communicate. The following extract comes from session one, which was attended by Harry and both of his parents.

> *Harry said to his mother that he needed the toilet again. His father got up to take him and I reflected on him needing the toilet twice today. Mother said that he has 'very good bladder control', and, therefore, today was unusual. I asked if she had any thoughts about this and she said no, so I said that I wondered if it might link to him feeling a little apprehensive about today – sometimes we need the toilet more when we are worried. She said that he could be, "I suppose", looking unconvinced. I asked how she had felt coming today and she said, "Fine, it's just another appointment to me".*

Whilst I was trying to think with Harry's mother about attending the sessions and how that might feel to Harry and them, Mother referred to Harry's physical bladder control and then her own feelings about this being just 'another' appointment. Although this is only a very brief example, it captures my wider experience with Harry's family, whereby it could feel difficult to explore a physical behaviour or action.

Perhaps for Harry's parents, and some of the other families, they had developed ways of making sense of their children's behaviours, and so I was experienced as challenging their interpretations or understanding. This was evident in some of my sessions with Amy and her family. During one session, I was told by Mother that she and Father had been discussing Amy's behaviour with her Uncle (who worked with adolescents).

> *Mother explained that Amy's uncle had initially suggested that she wasn't being "challenged" enough, so was getting bored and frustrated, leading to physical outbursts. She had replied to her brother-in-law that they had thought quite a lot about this already and had come to the conclusion that when Amy "chooses to control the situation" or "demands control", it is not about not being challenged enough, but rather something else. I wanted to pause to think about her words, and this idea of things being Amy's choice or a demand, but Mother continued talking. She went on to say that after this conversation, Amy had become upset, and had thrown gravel at her uncle, which had shocked him. He had said that she should be made to tidy the mess up and later on he had suggested that her behaviour fitted in with a diagnosis of Oppositional Defiant Disorder (ODD). Mother added that of course they do not want to interfere with my work, but she was interested to know if I knew of ODD and whether I thought that fitted.*

This led onto discussions regarding ideas of choice (Amy's parents believed that she chose to behave in these ways) and why Amy might feel she needs control. During my work with Amy's family, we thought a lot about her early experiences with her birth parents, including in-utero and in the first months of her life. I learnt that Amy's birth mother had been misusing substances throughout the pregnancy and there had been a great deal of change, unrest and upset during Amy's early infancy.

We spent time wondering about what might lie behind her behaviours at times, and I encouraged them to consider that although Amy was not outwardly able to talk to her parents about feeling worried or anxious (as her older brother did, I was told), I thought a lot of her behaviour might be driven by deep anxieties, linking to change, relationships with others, and other people's view of her (which may have linked to her stone-throwing at her uncle). Amy also helped us to think about these things, and how physicality might be a response to powerful feelings. In session one, Amy had been quiet and withdrawn initially and a little wary of me. Later in the session, she began to play with the animals:

> *She began to empty the animals out and commented on the gorilla. I picked up an animal and said it was an unusual looking one and she said it was a lizard. She then began to stomp on the lizard with the gorilla, saying the gorilla likes to "beat his chest with both hands". I asked about the 'stompy' gorilla, suggesting that he sounded cross and she said he was. She noticed that there was a daddy, a mummy and a baby deer, and a baby polar bear. She said the gorilla had no friends, and he became "stompy". I said that the gorilla was all on his own and that made him cross and stompy. She then moved one of the other animals nearer and I asked what was happening and she replied saying that the gorilla also wanted the lizard, so I brought it closer. She said that they were friends and were playing, adding that the gorilla was happier now.*
>
> *I said that I had wondered if the gorilla was quite lonely before and she agreed, explaining that was why he (the gorilla) had been angry, but now "everyone is all together" – and she moved all of the animals around the gorilla and they began to play together.*

This short piece of play seemed to capture something clearly, specifically the way that the gorilla, which perhaps represented Amy, became ‘stompy’ (i.e. physical and aggressive) when he was lonely. This feeling of loneliness, and being on his own, was expressed physically, but once the difficulty had been resolved (and friends were found), the gorilla settled down. I think that this play linked not only to Amy’s earlier presentation in the session (perhaps I was like the odd-looking lizard, who Amy was initially wary of), but also Amy’s experiences more widely. I have wondered if Amy felt somewhat excluded at times, different from her peers, although she did not know why. There was certainly, in the room, a powerful sense of Amy appearing quite isolated or distant, especially in the earlier sessions.

A further aspect of physical expression to be considered was how the physical environment (the clinic and the room) was used by the families. As mentioned previously, it was interesting for me to note how the families related to their sessions – were the appointments difficult to arrange, did the families arrive early or late, did the children stay in the room during the sessions, and how were the endings managed? Additionally, I also observed how the different parents engaged with their children differently within the session times. For example, for the first two sessions, Scott’s mother mainly remained sitting on a chair, despite me and Scott sitting on the floor, and my encouragement (and Scott’s clear desire) for Mother to join us. There were moments when she did join us briefly, but then there would quickly be a reason for her to return to her chair. However, during the third session, both Scott and his mother immediately sat on the floor, and she was, in general, more engaged with Scott throughout the session. I noticed how they played together, using the crafts activity which Mother had brought with them. It seemed that Scott’s mother’s physical availability reflected something of her being more emotionally available too; she seemed more interested in Scott today and her pleasure and delight in him was also evident during this session too.

There was also a response from some of the clinic admin staff, which seemed triggered by the physicality of the children involved in the project. As mentioned earlier, the clinic in which this pilot project took place predominately works with adolescents, despite being commissioned to work with 0-18 year olds. The presence of younger children, like my participants, seemed to elicit some concern and irritation within some of the team, which I think linked to the physicality, noise and unpredictability of this age group. I received telephone calls asking whether I could see the families earlier than planned and there was a sense of wanting to move the children into the clinic rooms, so as to avoid any disruptions in the waiting room. What was interesting to observe was that when I went to collect the children, I did not find them causing any particular disruption, but playing with toys, or drawing on the chalk boards, with the enthusiasm that one might expect from a child of their age. It seemed that these behaviours were challenging for some of the staff, and they needed the children to be stopped, or moved out of sight.

I have wondered how this links also to some of the parents' responses, and how the physical expression of the children was experienced as challenging and invasive. It seemed that the parents could struggle to contain some of their children's expressions, and this could lead to the children's responses escalating. I noticed myself how it was, at times, challenging to create any space to think when the child was crashing or bashing or leaving the room. I was aware of my own feelings of frustration, and irritability during these moments. I did, however, also notice how words could be incredibly soothing at times, and had the ability to contain the child's physicality, even if only briefly.

An example of this came in my last session with Bella's family. Bella was repeatedly trying to leave the room, whilst her parents told me that she had not wanted to attend today.

> *Bella returned with her mother and then tried to leave again, but Mother now stood in the way, so Bella went to the doll's house and threw some pieces on the floor, looking angrily at us. I said that I thought she was feeling cross about having to stay in the room, but I wanted us to try to finish off our final session together. She demanded that her mother move and that I sit on the sofa again, but Mother said she would remain standing because Chester was getting tired and needed rocking (although I think the purpose was to block the door). Bella shouted at Mother and made a loud screaming noise, before running to the heavy chair and trying to tip it over. The atmosphere in the room was now tension-filled, and I felt concerned that Bella was going to hurt herself. I stepped over and held the chair, saying that we needed to keep Bella safe and so the chair could not be moved. She made a very angry looking face at me and screamed again, trying to move the chair. I held my position and said that we understood she felt angry and did not want to stay in the room but it would soon be time to say goodbye, so we want to try and finish the session together in the room.*
>
> *I then returned to my seat and a moment later Bella came over, looking at the various items I had collected next to me (moved out of Chester's reach). She picked up the broken pen, and I commented that we had looked at this pen each session. She then spent a good minute or two, concentrating and trying to fix it. She allowed me to comment and help and seemed pleased when she had completed the task, and her mother also praised her. I thought about this*

> *idea of something feeling broken or damaged, and Bella's interest and wish in repairing this now, as we reached the end.*

It was striking how quickly Bella's mood and presentation seemed to shift, and the mood in the room also softened. I felt that Bella's feelings had been understood and commented on, and this allowed her to move away from the physical expression and instead engage in a task which explored themes of damage, repair and something reciprocal between us.

I felt that a focus of the therapy sessions was to help the families think about how thoughts and feelings are expressed, and how a shared and mutual language of expression could be created. The levels of physicality displayed by some of the children was clearly a worry to both their parents and other professionals, and there was a hope that this could change. However, in order to do this, we needed to find a way to think about both the child's levels and methods of expression, but also the parents' too.

This leads me on to my next theme, which focuses on the way proximity and distance were present within the sessions and seemed to link to the feelings and emotional states within the room.

v. Distance and proximity – a link to communication and connection

This theme explores how distance and proximity appeared within the sessions, in relation to levels of communication and connection between the family members and me, as therapist. Within the sessions, I thought about the way distance and proximity were used, and how this linked to the way in which thoughts and feelings can be expressed and understood. This theme was present in nine of the fifteen sessions, and it presented itself in a number of ways, some of which I will explore in more detail.

First, I want to briefly mention how the families positioned themselves in the room at the start of sessions, something which I have already referred to during some of the previous themes. For some of the children, close physical proximity to their parents was sought at the beginning of sessions; for example, Bella held hands with her mother as they entered the room, and seemed to seek reassurance from her initially. However, interestingly, other children, like Harry quickly sought proximity to me, even in the first session, when I was unknown to him. I noted at the beginning of session one how:

> *Harry found a piece of the doll's house and asked me, with surprise, where it went. I was struck by his deep brown eyes and engaging smile. A moment later, he came over to me and stood close, telling me about his toys at home*.

I recall feeling curious about his immediate engagement with me, and apparent disregard of his parents in these early moments.

For some of the families, this proximity between parent(s) and child changed as the sessions went on, which may have linked to the family member's changing feelings towards me and the therapeutic-space, but also to their relationship with each other. An example of this, as mentioned previously, was how Scott's mother sat on the floor, close to Scott, during session three, something which she had seemed reluctant to do previously.

Second, proximity and distance at times seemed to be used to help the child manage something, and it appeared to be an important part of their communication with me. For Bella, there seemed to often be a fluctuation between complete connection and physical contact, to a complete disconnect and distance. It has been suggested that if young children have not been facilitated, by their parents, to develop '*a sense of* *boundaried internal space'* (Hurley, 2017: 200) they can develop adhesive ways of relating to others. We might think of Bella's presentation as being somewhat adhesive at times, either being joined in a 'stuck-together' kind of a way, or ripped apart in what could feel like a harsh or violent way. I will now track some the movements and changes in Bella's use of distance and space.

In the first part of session one, I noted:

> *Bella (who was drawing) lent on the table and it slid forwards. I commented on the table moving and suggested I would put my foot on one side to try and keep it still. Bella said something to her mother about fixing it on the floor, but Mother said that they couldn't, as they needed it to be able to move. Bella then wiggled the table a very small amount, which I commented on. She grinned and then moved it towards her and Mother. I said that now I could not reach the table, it was Mummy and Bella's table. She smiled and said that I couldn't reach it. She then moved it back and I touched it, saying it was a shared table again now. She grinned and then moved it back towards them, but this time she bumped Mother's shin with the edge of the table. Mother let out a small sound of pain and told Bella she needed to be careful. Bella moved the table a little more, before settling in back into a middle position, where both of us could reach it.*

It seemed that Bella was exploring something to do with our proximity. The table started as a shared space, but then became hers and her mother's, so close it painfully bumped Mother's leg, and was out of my reach. However, after some toing and froing, Bella settled on the table being in the middle, something shared between us. Later in the session, I observed again her need to pull the equipment close to her, so things were touching and without gaps.

Bella also explored distance and proximity with her own positioning to me, and I observed a very similar sequence of events in both session one and three. In session one, Bella became quite chaotic towards the end, throwing pens and trying to leave the room (thus creating a distance between us), and I found myself having to physically hold the door shut as she was trying to leave so frequently. I began talking to her about the time left, and suggested that I would show her on my watch, which led to a sudden shift and Bella coming close to me, and delicately touching the face of my watch, calmly and intently listening to my words.

In session three, I noticed a similar response. She was again trying to leave the room, so I suggested that we would look at my watch and I would explain about the time left. Again, Bella seemed interested in this, and stopped screaming and trying to leave the room and came close, pressing herself into the side of my body, and gently touching my watch-face, as I knelt down next to her.

I found myself wondering, as the sessions progressed, if Bella felt that she needed to be close and physically present, in order to feel some kind of connection with the adults around her. In session three, Bella again demonstrated this need for things to be so close and connected:

> *She handed me the book and asked me to read it, but then ran over to Mother and grabbed her hand, telling her to come too. Bella sat right next to me on the sofa, and encouraged her mother to sit very closely next to her, so we were sitting tightly in a row. I reflected on how Bella wanted us all right next to each, and close together. There was something warm about this closeness, but also something quite controlling, as though we all had to be right next to each and pushed together for Bella to feel content.*

A little later in session three, Bella wanted us to play hide and seek again. She insisted that she hold one of my hands and one of her mother's, meaning that we again found ourselves in a row. Then, each time Bella hid, she would shout out or give us clues to her location, ensuring that she was quickly found. I think this play linked to Bella's fears of being forgotten or getting lost, and there seemed to be a fear that if she was not in close physical proximity, then she was out of sight, and perhaps out of mind, which seemed unbearable for her.

I learnt more in later sessions about the times when Father works away, and how he does not speak to Bella during these times, unless she has been 'naughty'. Again, this made me think about how Bella could feel she could remain in the adults' minds, perhaps she believed she would need to be physically close, or 'playing up' in order to remain in focus. It is again interesting to think about the commencement of Bella's more challenging behaviour, just around the time that a baby cousin was born, and Mother became pregnant, both of which would have meant that the adults around her would have been thinking about other children, and perhaps Bella experienced being somewhat forgotten or lost during this period.

Finally, for Leila, proximity and distance seemed to link with her experience of being a looked after child, who had experienced severe neglect whilst in the care of her birth mother. She had been suddenly separated from her mother and family and the area in which she had grown up, and taken to live with relatives, whom she did not really know. Running through Leila's history were themes of togetherness and separation, connection and disconnection.

It became apparent that Leila being able to manage her distance and connection with her carers was very important. Within the sessions, a game emerged, involving a paper aeroplane, which Leila's mother had made for Leila in the first session. This aeroplane became quite significant and it was used in four of the five therapy sessions. Another frequent occurrence was Leila making a den within the room, into which she could retreat and emerge, at her will. Both things seemed to carry a particular importance for Leila and her connection and proximity with both me, and her carers.

The following vignette comes from session five, attended by Leila and Mother:

> *Leila explained that the aeroplane would go from Leila to Mother, from Mother to me and from me to Leila. After a few throws, Leila moved to the chair next to me, meaning we were now very close, which made throwing between us difficult. As we continued, she edged closer and closer and there was a feeling of us joining together, whilst her mother seemed quite separate. Mother seemed to notice this too, and raised an eyebrow and smiled. I commented on how we were so close that we could not really throw the aeroplane between us now, but instead we would just pass it. I also mentioned how the aeroplane is a bit like our words during sessions, sometimes two of us speak, whilst other times the three of us speak.*
>
> *The play seemed to evolve, so soon Leila and her mother were throwing to each other, whilst I was not so actively involved (which was in part because of Leila being so close to me). Leila sent some very light passes to me, but those to her mother were more forceful, bordering on aggressive. She then disappeared behind the chair, saying to Mother, "You can't get me", in what felt like a playful but slightly confrontational tone. There was a different feel to this play now, and there seemed to be something competitive or challenging about Leila's advances to her mother. Mother also set about trying to 'get' Leila. I*

> *noticed how I was not a part of the play now, and I thought about our ending. I reflected on how much of our time in the session had been spent in a three, but now it was clear that they were in a two, and I was an observer. I was left to observe their play, which carried an undercurrent of frustration, aggression and rivalry.*

This extract seems to capture some of the confusion within the room; was Leila moving close to me to exclude her mother, or was I the one being excluded? The aeroplane, as mentioned in the extract above, had seemed to link to our relationship in the room, something moving between us – sometimes a connection was made, whilst other times something was missed and the throw had to be re-tried.

I think this play certainly linked to our ending, but it also gave me an insight into Leila's parents' experience of being with her, whereby the connection could move between being very close, to suddenly more distant. It could also be that the changing levels of distance and proximity within this play, reflected something of their wider relationship too. Leila might experience her mother and father as being both close and comforting, but also potentially quite distanced, which could be disconcerting.

The following extract comes from session three, during which Leila had wanted to make a den, behind some armchairs, and her mother was helping her:

> *Mother set about moving chairs and laying the cushions behind them, creating a sort of secluded bed for Leila. Leila seemed delighted and lay down, and then said that she wished she had a blanket, so Mother suggested that Leila could use her cardigan if she liked. Leila nodded and happily wrapped herself in the cardigan and lay down, taking the teddy bear (that I had brought along) with her.*

I observed how Mother responded to Leila's requests in a gentle way, making suggestions and providing help, or comfort (the cardigan) without forcing or insisting proximity. Leila appeared to respond well to this, allowing the help, but then still retreating into her own space. When I mentioned Leila seeming comfortable in her little den, and asked about how she is at home, does she like to be on her own, or does she seek others for company or comfort, Father said that she was very "used to" self-soothing (because of her early history), so often she chooses to be on her own, but sometimes she wants more proximity.

When Mother sat back down, she said that she could tell Leila has gone back into a baby-like state now, and I said that the cardigan reminded me of a baby being swaddled and wanting that tight, holding, comfort. I commented on her doing this for herself, rather than seeking physical comfort from them, and her parents said that it can really depend on what mood she is in, sometimes she is very cuddly, but at other times she likes her own space, which they respect.

Leila's mother said that Leila seems to move in cycles, from wanting them close by and, for example, a kiss goodnight, to not wanting them near, telling them to "die" and "go away". She explained that they always offer a kiss and cuddle, and never try to give one without checking that Leila wants this. I asked how long the cycle lasts and was told a couple of weeks usually. Mother mentioned that this also seems to link to what names Leila calls them – most of the times it is mummy and daddy, but it can be their first names, or Aunty and Uncle. I nodded and said that I had noticed this within the sessions. I commented on the confusion or conflict expressed within these different names– sometimes feeling very close and connected, whilst perhaps other times feeling more conflicted, or in association with other parental figures.

Proximity and distance for Leila, therefore, seemed to link to her emotional connection to her carers, and it seemed that her feelings could change frequently. In the room, this was reflected by Leila at times showing indiscriminate affection towards me (such as bringing me gifts) whilst at other times withdrawing into her den, and finding ways of regulating the contact or connection. During the last session, there was a particularly poignant moment, during which Leila made the toy telephone ring, whilst she hurriedly stuffed crisps into her mouth, as though she were afraid of missing a piece, or the pack being taken away from her.

She had used this telephone in earlier sessions and the ringing had usually led to some conversation about the person at the other end. In this session, however, when I asked who was on the telephone, she told me frankly, "*no one*", explaining that *she* had made the telephone ring. There was something painful about her frankness, as though the imaginative play, demonstrated previously, had gone, and in its place was the reality that no-one was on the telephone – there was a disconnection. I later heard that Leila had been talking increasingly about her birth mother during the week, and I thought back to the empty telephone line and how the absence of the caller might link to the absence of contact with her birth mother, but also with me, as it was our last session.

This theme has captured the way in which proximity and distance were used within the session, in relation to the connection and communication between the family members, and me. Within this theme, I have made reference to the way in which distance and proximity related to the physical interactions within the room; the expression of feelings; and family setups and relationships.

I shall now move on to my final theme from the clinical sessions, and that is ‘The wish for more’, linking to feelings of dissatisfaction, having not had enough, or not being content with what was available.

vi. The wish for more

This was initially not one of the key themes identified in the session material, and I had anticipated that it might form a ‘sub-theme’. However, as I began to analyse the material further, and reflect on my own feelings about the work, I realised this theme was more prominent and significant than I had first thought.

For some of the children, there seemed to be something of an insatiable need for more. I believe this linked to a feeling that something was not fully being attended to, and, therefore, a need was not being fully met. The final session with Scott began with him and his mother having a disagreement in the waiting room and it emerged that Scott had been using her telephone, and when it had been time to pack it away, he had become very upset, angry and physical towards Mother:

> *After a prolonged period in the corridor, trying to get Scott into the room, Mother eventually whispered something to him, which led to him immediately entering the room. Once inside, she offered him two sweets, “because you listened to me and came to the room”, but Scott argued, insisting that he wanted more, three or four sweets. Mother agreed that he could have more at the end… When it came to the end of the session, and I said that we would need to tidy up, Scott objected, saying he did not want to end and that he was still playing. He had begun putting all of the doll’s house equipment into one room of the house, cramming everything in. It seemed that there was not enough space for everything to fit, and things looked cramped and uncomfortable.*

Within this session, there was a powerful sense of Scott wanting more; more time on Mother’s telephone, more sweets, more space (in the doll’s house) and more time together; what he did have did not feel enough. For Harry, the theme of wanting more came up several times in terms of hunger. He spoke freely about food and hunger and when I commented on this, I was told by his parents that he was always hungry, even straight after eating he would say he wanted more. Again, an idea of being unsatisfied or unfulfilled came to mind.

With Amy, this theme seemed particularly salient at the end of the sessions, particularly as the sessions progressed. During session one and two, Amy was fine leaving at the end of the session; however, in the following three sessions, she refused to leave, lying on the sofa, pretending to sleep and ignoring our encouragement. She said she did not want to go, or that she wanted to play more, and in the final session, when she had eventually managed to leave the room, she stood holding the corridor wall, as though hugging it, unwilling to walk towards the exit. This wish to stay, or have more was particularly interesting for me, because it very much aligned with my own feelings of wanting to offer her further work.

I found myself wanting to continue working with Amy, and at times I imagined what it might be like to work with her individually, although in reality I knew this was not possible. There was something about the way Amy engaged in the work, which left me feeling that she needed more, and that I wanted to give more.

It is interesting to note, therefore, that the other child for which this theme was particularly present, was Leila. I have wondered about the fact that Amy was adopted and Leila with special guardians and what impact this might have had on their wish for more. They have both experienced significant early deprivation and loss, in their individual ways, and this could be associated with later feelings of needing something different, or more than what they have had.

At the start of our first session, when Leila was shown the available toys, she said, unimpressed, that they were not right and she wanted something else, although she could not say what. She also requested a drink in every session, and would try to access parts and contents of the room which she had previously been told were not for her (for example, paperwork stored on a shelf). In the last session, this want for more was very clearly expressed:

> *I alerted Leila and her mother to the time, saying that we had five minutes left. Leila frowned and said "Oww". I said that I would be speaking to her parents in a few weeks and hearing how everyone is getting on, and Leila said "so I can come and play again?". I confirmed that today was our last session, but she did not reply. I offered an appointment time for the review and Leila's mother confirmed it should be okay, and that her husband would be able to attend too.*
>
> *Mother began to tidy up, whilst Leila said that she wished she could take the stickers home with her, but that she knew she couldn't. I agreed that she couldn't but said she could select one more, and she replied, "I wish I could take two", but I said she could take one. The need for more was so evident, as it has been throughout the work. Leila selected a sticker and said she wanted to put it on her folder, asking if she could take her drawings home, adding that she would like to keep her aeroplane and be able to show everyone what she's done here. I said that it sounded important for her to have something from the sessions to keep, I commented on her bringing me something today (some*

> *freshly picked flowers and a piece of art made at school) and how she wants something to take with her – perhaps to keep her in my mind, and me in hers.*

As I said goodbye to them at the end of the session, I recall feeling sad, and considered the goodbyes Leila had experienced in the past, and how I had become part of another one.

I think this theme links not only to the individual families but to the work generally, both in terms of the limitations of brief working and the fact this was a pilot project. Following my interventions with the families ending, I spent time in supervision discussing the cases and it became clear that this wish for more was not just within the families, but within me too. I felt that five sessions had not been enough for the families, and all of them needed (in varying ways) some on-going support. I did, therefore, find myself somewhat tied, I had built a relationship with the families, and they had all engaged in the work in what felt like a meaningful way, but I had to end with them. As explained to the families at the beginning, part of my role was to sign-post them on for further support, if required, because I was unable to continue offering them parent-child sessions.

It seemed that, because of the short-term nature of my intervention, even at the start of the work, some of the families conveyed a sense of wanting more than five sessions. For example, in my first session with Scott, his mother discussed session times and referred to dates in August. This was despite our appointments actually being scheduled to end in June. Meanwhile, Harry's mother repeatedly referred to wanting to know what the future plans were and in her review, she wrote on the ESQ form that she was *"looking forward to hearing the action plan/next steps".*

For some of the families, it appeared that they would like more parent-child sessions, whilst for others it seemed that it was just important to know what the next step would be. This may have linked to anxiety within the parents about being left on their own, having to manage difficult feelings and experiences without professional support. This seemed to ‘soak’ into the networks too, and I recall having numerous telephone calls with different professionals (for all the families), asking what I would be offering next.

It was clear that the families did need further support, in some form, from various different services (see Postscript chapter for full details). Both Leila and Amy’s families were referred on to a post-adoption charity locally. For Bella, a referral was made to our family therapy team, in order to continue thinking about the intergenerational and systemic patterns in-play. For Scott and Harry, I remained involved in a somewhat removed way, attending meetings and liaising with the professional network. It seemed that this shift in engagement was a challenge for me, and the families, as well as the other professionals involved, and there were questions raised about why the work was not continuing. In this way, the limitations of the research project, and the CAMHS service generally, felt somewhat punitive – I was unable to offer more, despite there being, in some cases, a need and a wish for more.

Although this theme, a want for more, did not seem immediately obvious in my initial data analysis, as I became more familiar with the data and my understanding of it increased, I came to see that a wish for more appeared in several ways during this research project, in terms of the children, their parents, the professionals and me. Despite this theme perhaps having fewer dimensions than some of the other themes, I think it is an important one, especially in relation to the wider implications of this study and this is something I will say more about within my conclusions chapter.

Having explored the themes generated from the clinical interventions, the next chapter will address the data gathered from the semi-structured interviews, goal based outcome measures and ESQs, as well as my presentations to the team.

Findings

Part B –the interviews, outcome measures and team presentations

In this chapter, I am going to look at the data gathered through the outcome measures. Those were the semi-structured interviews conducted at the start and end of the therapeutic intervention, including treatment goals, and the Experience of Service Questionnaires (ESQ), completed in the review session.

I will look at each of these measures (interviews, goals and ESQ) individually, but I will also make some comparisons between them, as it is interesting to think about how the feedback from each of them corresponds with the others, and whether they capture similar or different experiences of the project. I shall begin by addressing the data from the interviews.

At the end of this chapter, I will give a summary of the outcomes from the team presentations, which took place at the beginning and the end of the project.

i. Interviews

The interviews were based on a semi-structured question schedule (see appendix viii), in order to try to capture similar information from each of the families. However, because of the nature of psychotherapeutic work, and the fact I wanted the families to feel that they could come and talk to me freely about the salient issues for them at the time, the conversations within the interviews were relatively free flowing. Whilst I did introduce each of the questions if they did not come up naturally, the conversations often took other paths. When I wrote up these interviews, I tried to fit the data into one of the question titles, as far as possible.

I have decided to present the data from the interviews per question, reflecting on the themes from the first interview which took place before the therapy sessions ('pre-treatment') and then looking at the themes from the follow up interview which took place when the therapy sessions were complete ('post-treatment'). I have chosen to address the data in this way because I hope to capture if and how the themes changed or developed from the start to the end of the project.

For each of the questions, I will summarise the main themes gathered from the data. Some vignettes will be used to give more specific details about the answers given by particular parents. When considering this data, I think it is important to keep in mind that the questions (listed) were very much prompts and the responses were, therefore, quite open-ended in their nature.

It may also be worth recapping who attended the interviews, as we might consider if this had any impact on the focus of the answers. Although fathers were included in some of the therapy sessions, no fathers attended either the pre-treatment or post-treatment interviews. Scott and Leila (along with one of Mother's birth children) attended the pre-treatment interviews with their mothers.

Question one

What brings you here today? What has been worrying you?

The aim of this question was to see what was particularly present in the parents' minds, in terms of their concerns about their child and why they felt they had been referred to the CAMHS team and the pilot-project. I think it is always helpful to ask parents this question because it gives an insight into their understanding, and not just the understanding of the professional(s) who have written the referral.

Pre-treatment interview

This question, in the first interview, had three overarching answers, from most of the families.

Behavioural difficulties: the most prevalent answer given was that concerns about the children's behaviour was what had brought the families to CAMHS. All five families mentioned this as their primary concern, although the specifics varied between families. For example, Harry's mother referred to Harry having "daily freak outs", which involved him screaming, shouting and hitting. Leila's mother referred to Leila regularly soiling herself, despite seemingly having been completely toilet trained previously. Several of the parents referred to the child seeking "control" and there was often an idea that their behaviour was a way of gaining control. Interestingly, there was also a powerful notion in some of the parents that their children "chose" to behave in certain ways, and, they did, therefore, believe that the child could also choose not to do so.

Impact on relationships: concerns regarding how the child's current presentation was affecting relationships within the family was another theme from this question, predominantly with regard to how the child related to their parent(s). Four of the five families identified this as one of the reasons for seeking support. Scott's mother referred to how Scott's behaviour seemed to escalate when they were in the presence of others. She suggested that when they were alone, his behaviour was much calmer and more settled. Bella's mother also said that Bella managed far better when she had one-to-one adult attention. Both of these comments seem to capture something of the child's challenge of sharing, and how within the safety of the parent-child relationship, the child felt more calm and contained.

Emotional expression: the other most prevalent theme from this question referred to the child's struggles with the expression of their feelings. Harry's mother shared worries about how his mood quickly fluctuated and how it was sometimes very hard to know what had led to this shift. Harry's mother seemed to be noticing and struggling with his expression of his emotions (which she felt to be erratic and puzzling); however, she also went on to say that she believed "Harry has never had emotions" and his responses were learnt and not genuinely felt or experienced by him.

Leila and Amy's parents mentioned how their children's behaviour and emotional responses seemed to regress at times, seeming more reminiscent of much younger children.

I think underpinning these comments from the parents was something to do with their puzzlement about their child's emotional expression. Feelings of miscommunication, distance and frustration were very present in the answers given. There was a sense of uncertainty, worry and confusion and most of the parents were clear that they wanted to understand their children better.

<u>Post-treatment interview</u>

Behavioural difficulties: the most striking change, when looking at the answers to this question at review, was how the reports of concerns regarding behaviour had significantly reduced. In the first interview, all the parents had referred to the child's aggression, upset or other associated behavioural challenges, but at review this was only mentioned by some of the parents. For three of the families particularly (Scott, Bella and Leila), the answers to this question now centred more on systemic concerns or particular behaviours and the trigger for these. For example, Scott's mother raised concerns about the impact on Scott of contact with his birth father and reported that

Scott's behaviour would often significantly change around this time, giving an example of Scott having soiled himself before contact. Leila's mother talked about the strain of Leila's arrival on the family, and how her behaviour had an impact on the other children and had created conflict between Mother and Father. It seemed that whilst the children's behaviour or physical expression of feelings was still a concern, the lens had widened and now the parents were thinking more about other family members – I will say a bit more about this in a later theme.

Thoughts of the future: at review, understandably, several of the parents said that they were there to review the work we had done together, and think about any future support that might be needed, or wanted. It is, perhaps, unsurprising that this would be a prevalent theme, especially as all of the families required some form of on-going support and none were ready for immediate discharge from the CAMHS team. I also think that this theme might link to the families having been offered brief work, which, for some, did not feel enough and so their thoughts turned to 'what is next?'. Amy's mother, for example, asked whether it was possible for a 'CAMHS trained teaching-assistant' to be made available at Amy's school. She also advised that I should speak to school about various matters, which linked to an idea of extending my involvement and keeping my support/input in place.

Thinking 'family': during the post-treatment interviews, the parents raised more thoughts about themselves, their other children, or the family as a whole. The following vignette comes from the post-treatment review with Bella's mother:

> *Bella's mother said that she is still concerned about how Bella is with her little brother (which had been the primary concern at the outset of the project); but her other main focus is family life as a whole. She referred to Bella's father's*

> *temper, short-fuse, and difficulty moving on after disagreements. She said that she feels this is more of an issue now than it was when she first met with me and she now has concerns about their relationship, because it believes that if her husband does not get support for himself, it will have serious consequences on them as a couple. Mother said that Father now says he is better and does not need support, but she thinks that "things can't improve with Bella, until he gets help".*

This was a significant reflection because it recognised how interconnected and related Bella's functioning and presentation was with her father's. It was very hard for Bella's mother to identify this, and she became tearful afterwards, but I think she also felt some relief that through the therapy sessions we had been able to think about this together, and so the focus was no longer only on Bella.

Feeling positive: another theme from the review interview was that the parents were more able to identify some of the changes which had taken place in the time since our initial interview. Scott's mother, for example, said that she felt Scott was "not just doing really well, but really, really, really well – perfect in fact". Although this idea of 'perfect' did not align completely with her other feedback and comments from the professionals involved, what I think this comment did capture was Scott's mother's increased capacity to see something positive in Scott, something which she had often found hard during the sessions.

In summary, in the first interview, the parents' answers to question one referred mainly to concerns about their child's behaviour (predominantly the expression of their anger), and the difficulties they perceived their child had in expressing emotions – both of which they felt had a negative impact on the relationships within the family.

In the review interview, the answers focused more on the functioning of the family as a whole, with parents making reference to their own needs and difficulties, as well as those of their children. There was a bit more space to think about the strengths and things which were going well for the child, alongside questions about the future. It was clear that although some of the parents felt things had improved in some ways, there was an evident wish and need for on-going support, either for the child individually or for the family.

Question two

Do you have any ideas about what might have caused this difficulty/difficulties? How have things been at home generally, what has been going on?

This question aimed to explore how the parents understood the current difficulties and what impact these were having on the family.

Pre-treatment interview

Quite a variety of answers were given to this question, and it seemed that the parents had different ways of thinking about and understanding the possible ‘causes’ or contributing factors to the current situation.

Early history: four of the five families referred to an event(s) or situation occurring during the child’s early years, which they thought could be contributing to the current difficulty/difficulties. Harry’s mother referred to the sudden death of her father the previous year, which had a significant impact on the whole family, as Harry’s grandfather had been a central figure in all of their lives. Bella’s mother mentioned Bella suffering from a reoccurring health condition in the first two years of her life, which required hospitalisations and various medical interventions. She referred to the high levels of pain and distress Bella had experienced during this time.

Leila's mother referred to Leila's experience of neglect and abuse whilst in the care of her birth mother, prior to her move into care; and Scott's mother mentioned domestic violence which had taken place within the family home, perpetrated by Scott's father towards her. This violence had taken place during pregnancy and after Scott was born. Mother identified that this had had an impact on Scott, and she referred to his play, in which he acted out scenes with a "nasty daddy who used to shout at you (*mum*)".

The mention of these early events or challenges was recognition that these experiences would have had an impact on the child. It represents the parents' ability to think about their child within the context of their own, and their family's, life experiences.

Organic causes: for some of the parents, there was an idea that a neuro-developmental condition could be the cause or explanation for the current presentation. Harry's mother mentioned extensive tests and assessments Harry had undergone, but how no formal diagnosis had been given, much to his parents' disappointment. Leila's mother also queried whether there could be an organic cause to Leila's difficulties; however, this was mentioned with some hesitation and she did say that she understood attachment-difficulties can present in a similar way to autistic-spectrum disorders.

Post-treatment interview

Whilst some of the answers given to question two in the review interview were very similar to in the pre-treatment interview, there were some interesting new themes which occurred.

The wider family: the most frequently occurring theme from this question was the mention of the referred child's siblings, in terms of either their own difficulties, or strains to the relationship between them and the referred child. We might summarise this in terms of the parents being more able to consider the needs, challenges and presentation of other family members, and how these factors may be contributing to the current situation with the referred child.

Harry's mother, for example, talked at length about concerns regarding her other son, Reece, and how she feels that he is on the edge of a 'diagnosis' himself. We were able to think about this together and Harry's mother did agree that her concerns about Reece may have been unconsciously making her more eager to seek support for Harry, before he gets older and the situation escalates. Leila's mother also referred to the situation at home, and the needs of her birth child and how it can be a struggle to meet and manage everyone's specific needs within the family.

Early history: whilst this was a theme in the pre-treatment interviews, I want to refer particularly to the shift in Amy's mother's response to this question in the second interview. In the first interview, it was striking that Amy's mother was the only parent who did not mention the impact of Amy's early experiences and adoption as a possible contributing factor to the situation now. Below is a vignette from the post-treatment interview with Amy's mother:

> *Amy's mother said that she and the family "had not considered attachment to be something as serious as what we were seeing in Amy", she explained that she imagined if a child was adopted at such a young age, then it would not have attachment difficulties. Mother said that in fact she had thought that if a child was with their birth family until they were seven years old and then adopted*

> *they might have attachment difficulties, but if the child was adopted in infancy, attachment would not be such a problem. She described herself as probably having been 'naive' about this.*

This was clearly a huge shift in Amy mother's thinking and understanding in relation to early trauma, loss and separation. Whilst in the pre-treatment interview, she had identified high intelligence (and associated frustrations) and attention-seeking as the causes for Amy's presentation, by the follow-up there was space to consider Amy's early years, and how this might be contributing to the current situation, despite Amy's early adoption.

Amy's mother also went on to say that if she and Father had fully understood the impact of early experiences on later development, and some of the difficulties they might encounter, then they might have thought that they did not have the skills to adopt. I include this because not only does it demonstrate a shift in Amy's mother's thinking, but, through my counter-transference, I felt in touch with Amy's mother's comment, in relation to the project. I felt, at points, that I lacked the skills required, and fleeting thoughts did cross my mind about whether I had been a little 'naïve' or, perhaps, omnipotent in thinking that I, in five therapy sessions, would be able to help these families, who were experiencing such high levels of distress. The evident shift or progress indicated by Amy's mother's comments above (regarding her view of attachment prior to the intervention) was difficult to hold on to and I found myself, at times, feeling a little bit unsure of myself or my role, which seems to clearly mirror Amy's mother's (and perhaps father's) experiences in relation to parenting Amy.

Current contributing factors: I want to make a brief mention of the fact that in the post-treatment interview, some of the families identified causes linking to particular situations or influences at that time. These were areas that had not been significantly mentioned in the pre-treatment interviews. For example, Scott's mother mentioned (in the post-treatment interview, goals and ESQ) Scott restarting contact with his father, which she felt was having a significantly negative impact on his functioning and wellbeing at that time.

Meanwhile, Harry's mother talked at length about the new jobs that both she and Father had taken on since the therapeutic work had begun, both of which had had a considerable impact on the daily routine for Harry and his brother. It is perhaps difficult to say what the mention of these new contributing factors meant, but I think, especially for Scott's mother it made it difficult to assess how she had found the therapy. The situation with Scott's father felt so overwhelming and concerning that there was a powerful wish to continue the work together, in order to focus on this new situation, despite this having not been one of the concerns at the point of referral.

The answers to this question focused more on the possible causes, rather than how things have been going in general; although I think the latter did feature through the answers to all the questions in some way, especially question three. There were quite a variety of answers given regarding possible origins, ranging from early trauma, to organic factors to systemic difficulties. In the post-treatment interview, the parents made more reference to the family as a whole, and their child's early experiences. I think we also saw how quickly situations and concerns changed within these families, even over a very brief treatment time.

Question three

How have you all been getting along with each other in these difficult circumstances?

The purpose of this prompt was to see how the parents felt that the family was functioning and managing, amidst the current worries and concerns about their child. I was hoping to give space to hear about both the challenges, but also the things which were going well for the families.

Pre-treatment interview

Professional support: the most prevalent theme was the importance of professional support and liaison. It seemed that additional support was felt to be something which kept the families ‘going’. For some of the parents, this was support from nursery, school or health visitors; whilst for others, this took the form of more specialist support, for example, speech and language therapists or paediatricians. For other families, like Bella and Leila’s, this took the form of the parents having sought information and advice for themselves, including parenting programmes or attachment training. It was clear how important the professional network was for all the families, and it was also evident that all the families had, to a greater and lesser extent, received some additional professional support, prior to referral to the CAMHS team. This seems to link to my previous observation regarding the high level of inter-professional liaison within this work.

It is also important to note, that along with professional support, some of the families also referred to the importance of support from their extended family members and the local Church.

The wider family: some of the parents, in answer to this question, referred to struggles experienced within the family, as a result of the referred child’s difficulties. Some of the parents, such as Bella and Amy’s mothers, expressed feeling high levels of doubt about their parenting and whether they were doing things ‘right’; whilst other parents referred to having been signed off sick at work, or fearing their health (mental and physical) was approaching a ‘relapse’.

It was also recognised by all of the parents that the presenting difficulties in the referred child were having a negative impact on the other siblings, in terms of aggression being directed towards siblings, struggles in sharing parents’ attention between siblings, and confusion and upset in siblings regarding the referred child’s presentation. It was clear that all the families were distressed about the impact the current difficulties were having on the family’s functioning and wellbeing.

Specific approaches: some of the parents referred to specific approaches which they had found helpful. I was told by Harry’s mother that maintaining a routine and structure was the way they had found to manage things; whilst Amy’s mother referred to “trying new approaches all the time”, the current one (at the time of interview) being “ignoring any negative behaviour” so as not to reinforce it.

For some of the families, their approaches focused on behavioural management techniques, which was reflected in their expectation that I would provide them with strategies to try. There was, in some cases, some disappointment when this was not the case.

Post-treatment interview

In general, it seemed that the post-treatment answers to this question focused on an increased wish in the parents to try and understand their child’s needs and to think about what other, different approaches or support might be needed to best meet these needs.

There was still the mention of professional support from most of the parents, but this did not seem to carry as much weight as it did previously.

What does my child need?: all of the parents referred, in one way or another, to trying to think more about their child's communication and what they might need in response. This including trying new approaches, buying new equipment and focusing on different things.

Scott's mother referred to trying to "listen to Scott's voice" more and think about what she can do to help him. I think this reflected Scott's mother's increasing ability to think about what she might have to offer Scott, and not only what the professionals might have to offer. Harry's mother referred to having more one-to-one time with Harry, and also listening to his requests regarding his bedroom – he had mentioned wanting soft, calming and comforting things in his room, such as cushions and a fish tank. Amy's mother referred to trying to help Amy recognise her feelings, and this was said to be done in a gentle, thoughtful way.

School: interestingly, all the parents referred specifically to how their child was managing in their education provision (either pre-school or school). It seemed that in this post-treatment interview the question of how they had been getting along was thought about in terms of within the home, as well as the outside world.

All of the parents reflected on some positive aspects of schooling (or nursery) at the time. This is likely to have been contributed to by the fact most of the review interviews took place in September-October, so school (especially for those starting school) would have been very present in mind. It might be that this theme was not so present in the pre-treatment interviews because the majority of the children were either just coming to the end of the term, or in their summer holiday, when the therapy sessions took place.

Changeability: it was clear from answers given that the parents felt that they were ‘getting along’ in variable and changeable ways. In the post-treatment interviews, there was certainly more space to think about some of the things which were going well; however, there was also the mention of things continuing to be very difficult. I think this represents the multiple facets of the parents’ concerns, including the child as an individual, the family as a whole, the child in the home, and the child at school. The parents seemed to identify some strengths and developments in some of these areas; however, they were not always present across the board, which seems to link to the complex and inter-relational nature of the difficulties; whereby the child’s functioning and wellbeing so closely linked to that of the other family members.

Whilst support from others remained a prominent theme in the responses to this question both pre and post treatment, what has emerged from the data is that in the post-treatment interview, the parents’ thoughts seemed to focus more on what they might be able to offer their children, in response to the current difficulties.

Question four

Have there always been difficulties? How have things been throughout (your child’s) life? Prompts could include – how were the pregnancy and the birth, and can you describe the early relationships?

This aim of this question was to think about the duration of the presenting difficulties, and to encourage the parents to think back to the very beginnings of their relationship with their child, including thoughts about the parental relationship, the pregnancy, the birth and the early years.

Pre-treatment interview

Longstanding difficulties: four of the parents (Scott's, Harry's, Amy's and Leila's) all acknowledged that they felt that there had always been difficulties, and there was a sense of things feeling quite stuck and desperate. Some referred to the child having been hard to settle or soothe as a baby, whilst others mentioned changes and instability in the home environment during their child's infancy. Scott's mother focused on the violence Scott had witnessed as an infant, and her associated guilt, and how now she wanted to make things better for her children and avoid further disappointment.

Bella's mother was the only parent who felt that the difficulties were not present since Bella was born. She recognised that a move of house (having previously lived with grandparents) when Bella was nine months might have been significant, plus Bella suffering with a persistent health-problem, but said that she had only had more serious concerns about Bella since the pregnancy and birth of Bella's younger brother.

Parent-child relationships: another theme was how the child interacted with and responded to the parents. Amy's mother described how Amy would cry a lot as a baby, but when she was offered comfort from her parents, she would pull away or rock back and forth. Her parents had found her hard to comfort, and this left them feeling somewhat redundant.

Leila's mother mentioned how she believed that there is a "loyalty conflict" for Leila, meaning that as she starts to feel close to and safe with Mother (special guardian), she feels guilt and sadness about her birth mother. This may link to Leila's mother's reports (in sessions) of how Leila can appear to be getting close and connected to Mother and Father; but this is often followed by her rejecting them.

Some of the parents also mentioned feelings and experiences in their own lives, which had affected their child. Examples include the recognition of inconsistencies in their parenting approach, maternal guilt, parental mental health difficulties and external changes. These factors were raised in relation to their impact on the early bond/relationship between parent and child, as well as the on-going relationship, as the child has grown up.

<u>Post-treatment interview</u>

The answers given to this question in the post-treatment interview were generally shorter than those given in the pre-treatment interview. This may be because this question aimed to explore the onset of the difficulties and the early relationships between child and parent, so perhaps many of the answers remained the same. There were, however, some changes in answers, which are of interest.

The impact of early experiences: as previously mentioned, this link between the child's early feelings and experiences on their current presentation was widely acknowledged in the pre-treatment answers. However, in the post-treatment interview, this link was more frequently referred to by the parents, perhaps especially by Amy's mother:

> *Amy's mother said that she and Amy's father had held a view that these issues would either be overcome with time, or it would be discovered that there is something specific 'wrong' (i.e. a neurodevelopmental condition). Mother said "although I didn't want Amy to have a label, I guess really that's what I've been looking for". She added that "I realise now that it's not going to get better, so we're on a different journey".*

Although this admission from Amy's mother felt very painful to hear, I think it was also very helpful, because it represented her being more able to think about the possible long-term consequences of early trauma, loss and change. This comment also allowed us to go on and think about how change was possible, but it would require work and commitment, and it was not something that could just be quickly rectified – which I suspect had been Mother's fantasy. This leads me onto the final theme from this question, and that is to do with parental feelings and communications.

Parental feelings: in the post-treatment answers, there seemed to be an increasing acknowledgement about how the parental function and wellbeing very closely linked to the child's. Bella's mother's answers were particularly interesting, especially when we consider that she had reported in the pre-treatment interview that there had not always been difficulties, and things had only become more challenging following a move of house, and the birth of Bella's sibling. In the follow up interview, however, Mother's focus turned much more to Bella's father and his relationship with Bella:

> *Mother said that Bella's father has struggled particularly since becoming a father. We thought about what might be going on for him, and how seeing Bella in angry or defiant states might be difficult for him – especially if he sees things in her which remind him of challenging parts of himself or his own experiences with his father.*

Bella's mother identified that there had not always been difficulties with Bella individually; however, there had, in her view always been difficulties for Father since becoming a parent. It could be suggested, therefore, that it was not necessarily that Bella's behaviour was always particularly challenging or unusual, but that some typical toddler behaviours might have triggered something in her father, something uncomfortable and painful. Based on what was learnt in the pre-treatment interview and the therapy sessions, we could suggest that these feelings in Bella's father might link to his own experiences of being parented and his own very challenging relationship with his father, who was known to be violent and then absent.

Post-treatment, Leila's mother was much more open about her own, longstanding feelings towards Leila:

> *Mother said that she and her husband had not anticipated how hard kinship care would be, and she added that if they had known then they might not have accepted Leila. Mother said that they were promised help and support, but have received none, and feel left to manage on their own. I reflected on how although they are related, they had not really known Leila before her placement with them. Mother nodded and said "she was a stranger when she arrived". I could really sense her upset as she spoke, and how difficult and challenging this situation was for them all. She described feeling "resentful" towards her husband because Leila is from his side of the family. She said that she feels bad because she knows it's not his fault, "but I'm the one left to deal with it all, whilst he's at work".*

This exchange was clearly significant because it acknowledged that not only have there been longstanding difficulties for Leila as an individual, but there have also been challenges and conflicts for Mother (and potentially Father) too, in relation to kinship care, and the impact that Leila's arrival has had on the birth children and on the parental relationship. I think that prior to this conversation, Mother had tried very hard to keep her more challenging feelings at bay but, on reflection, they did enter the therapy rooms at times, for example, in her ambivalence regarding accompanying Leila to the toilet.

In summary, the answers to this question indicated that the families generally felt that there had always been difficulties present. This was reflected in answers both pre and post treatment; however, in the post-treatment interview, there was a shift in terms of how the parents thought about the difficulties. In this second interview, there was increased reference to the parental feelings and their own difficulties, not just mention of the individual child's difficulties.

ii. Goals

Question five

As part of this intervention, we will start by setting some goals for the treatment. What are some of the problems you would like help with, or goals you hope to achieve (if not already obvious from previous discussion)? Please rate each of these from between 0-10. We will review these goals at the end of the treatment, and at follow up, if possible.

The setting of goals allows us to evaluate the areas of focus or concern from the parents' point of view and to see what impact therapeutic intervention has on these matters.

The goals were set in the initial interview, and then reviewed in the post-treatment interview. Table 1 shows the goals which were set by each family, and their ratings pre and post treatment. In terms of the ratings, the lower the rating, the greater the indicated levels of need or worry relating to that goal; for example, a score of 0/10 would present high levels of concern, whilst a score of 10/10 would suggest that things are going well and the topic is no longer a concern. A higher score at post-treatment indicates that the parents felt that there had been some improvement or development in relation to the goal. It is perhaps important to note that because of the time-limited nature of the intervention we may not have expected a significant change in the goal ratings, as there was only a limited amount of work which could be done during this time.

Some of the families found the setting of a goal(s) a rather tricky task, whilst other families had a much clearer idea of what they hoped to achieve in the therapy. It is interesting to note that some of the parents initially responded to this task by mentioning goals for themselves; for example, Scott's mother said that her goal was to get back to work, as she had been signed off sick. We then had to try and think about how this might link more broadly to the idea of separation and Scott's potential anxieties about this.

Table 1: the goals and goal rating pre and post treatment, for each family.

Family/child	Goal	Rating – pre-treatment	Rating – post-treatment
Scott	For Scott to feel more confident being away from his mother	2/10	8/10
	To think about Scott's behaviour and what it might communicate	3/10	7/10
Harry	To help Harry process and communicate his needs	2/10	4/10
	To help Harry to be able to be less 'volatile'	1/10	3/10

Amy	To help Amy find a way of noticing and sharing her feelings (i.e. how Amy is able to express her feelings)	6/10	6/10
Bella	To have a better understanding of Bella’s relationship with Chester	1/10	3/10
	To help Bella better understand and express her feelings	3/10	2/10
Leila	For Leila to better recognise and express her feelings	3/10	3/10

There were some overlaps in the goals set by the different families, which was in part because I had helped some of the parents word their goals, as they found this difficult, but also because several of the families identified very similar focuses for the work.

In general, the goals seemed to fall into one of two categories (or themes). The first centred upon the way in which the child understands, processes or expresses their feelings; whilst the second refers to the child’s behaviour, in particular their aggression. These goals clearly correspond with the themes generated from question one in the interviews (regarding what had brought the families to the clinic).

When looking at these goals in terms of analysis, I was struck by how the goals referred to the child as an individual. Two of the goals (Scott’s and Bella’s first goals) did refer to the child's relationship with another person, but it seemed that the focus even of these was very much on the child, and what they bring to the relationship, rather than thinking about the relationship per se. It is intriguing that none of the goals referred to the parent—child relationship, despite this very much being the focus of the work and how the project was initially explained to the parents.

In terms of the ratings given to the goals at the start and end of treatment, there was generally some improvement. Of the eight goals set, five were rated as having improved, two were said to have remained the same, whilst one was said to have decreased.

I will now give a few short extracts taken from the parents' comments whilst reviewing their goals. They provide a little more context around the ratings and how the parents were feeling about these areas during the review.

Scott: Goal 1: *Mother said that Scott is much more confident going into nursery now and generally separates easily and enjoys the days.*

Goal 2: *Mother talked about listening to Scott's voice, and how important this is ... she mentioned that recently "I saw his anxiety properly for the first time". She went on to give an example from a recent incident, during which Scott had sought her for comfort, which she said was very different from previously, when he would have escalated his behaviour in response to the situation.*

Harry: Goals 1 and 2: *whilst discussing the goals, Harry's mother said that she just wants the right support for him. She said, "nothing is 'wrong' with him, but it's just something is different". I recall noticing Mother's emphasis on the word 'wrong', and I remembered that during the sessions she had often spoken so* *firmly about there definitely being something 'wrong'. Her language now seemed to reflect something less harsh, and less focused on diagnosis.*

Amy: Goal 1: *Mother began answering my question about the goal by saying "slightly better – but that's only because Amy has more support in school now". She then talked about school and how helpful the recent conversations with the SENCO had been. After several minutes of talking, she returned to my question and said that she could not really say that things have changed, so she would give it the same rating as at the beginning.*

Bella: Goal 1: *Mother said that in short bursts Bella did seem better with Chester, but then suddenly it could get too much and she would become aggressive.*

Goal 2: *Mother said that she did not think this had improved, as Bella still very much struggled to identify or share her feelings.*

Leila: Goal 1: *Mother said that the rating had not changed, and this led on to a conversation about how this kind of short intervention was unlikely to be able to address such complex difficulties, but we could, however, continue to think about what further support might be helpful on-going and our work together may function as an extended-assessment.*

I shall say more about the link between the outcome measure data (interviews, goals and ESQ) and the session data in the conclusion chapter; however, in brief it is clear that the themes from the goals do correspond generally to the presenting situation at referral to the service, and with the reports from the parents regarding why they were seeking support.

There is, perhaps, a question regarding the validity of goals, as an outcome measure, because they are set before the treatment begins and so, although they may capture the focus in the particular session during which they are set, these topics may not go onto be the focus of the therapeutic sessions as a whole (Moran et al, 2012). It is possible that in some of the families, their focus and, therefore, their goals, might have shifted as a result of the intervention. Bella's family comes to mind particularly, and in the post-treatment interview, Mother did refer to her main focus having moved from Bella's relationship with Chester, to Bella's relationship with her father. I believe this shift in Mother's views represents an important outcome of the therapy sessions, as now the focus was on Bella's father and the relationships within the family, rather than Bella individually. It has been suggested that at times it might be appropriate to re-set goals during treatment (Law, 2013; Jacob and Law, 2015) and so, had the intervention in my project been longer-term, then this might have been something to consider.

On the whole, the ratings of the goals improved when reviewed; however, this was sometimes only a small increase, so perhaps not indicative of a significant change. It is also interesting to consider what the numerical ratings mean for individuals, and how difficult it might be to assign a numerical score to very troubling and complex family difficulties. There is also a subjective element to a numerical rating and it is important to consider how different people may interpret the meaning of different numbers. In my project, only the mothers attended the pre and post treatment interviews, so they completed the goals and ratings on their own. I have wondered if the goals might have been different if the fathers had also been present, because the task of coming to a mutual decision between the couple regarding first, the goal, and second, the rating, may have been more challenging.

I shall now review the information gathered from the ESQs, as this adds another dimension of data when we consider how the families experienced the work.

iii. Experience of Service Questionnaires (ESQ)

The ESQ is used in order to learn about the patient's experience of the service, in general. It asks questions regarding various aspects of the patient's experience, including the therapist, the treatment and the clinic facilities.

It is important to remember that this questionnaire focuses mainly on the service user's experience of the service, rather than the clinical intervention specifically. Brown et al (2014) made the important point that the effectiveness of a service, or treatment, does not necessarily correspond with the service user's satisfaction. Therefore, whilst the ESQ gives us information about the user's experiences of the service, it does not necessarily gather information about clinical intervention, although this may, of course, be mentioned in the boxes on the reverse of the sheet.

Four of the families completed an ESQ in the review session. Amy's mother had opted for a telephone review, so during this conversation, we agreed that I would post a copy of the ESQ (and a pre-paid envelope) for her to complete and return. However, I did not receive the completed ESQ, although when I met with Mother, some weeks later, regarding a referral to the post-adoption agency, she assured me that she had posted it. From her tone, it was clear that she did not want to complete another copy, and I found myself wondering about her feelings around reviewing the work, as it had been quite difficult to arrange the review and I had sensed some ambivalence towards me (and the intervention).

Of the four completed questionnaires, two parents answered 'Certainly True' for all of the twelve tick-box statements. One parent selected 'Certainly True' for ten of the answers, and 'Partly True' for two; whilst the final parent chose 'Certainly True' for eight of the statements and 'Partly True' for the remaining four. These results correspond with the findings of the literature, regarding the high levels of positive feedback given during service user satisfaction measures.

I want to refer briefly to the nature of the statements included in the ESQ and how they link to the work of a psychotherapist generally. Whilst some of the statements focus on the practical side of things, such as the facilities or clinic location, others ask about the parents' experience of the therapist and how they felt through the work. For example, statements include, '*My views and worries were taken seriously'* and *'I feel that the people who have seen my child listened to me'*. These statements touch on what could be described as some of the core aims of psychotherapy – we would always aim for patients to feel taken seriously, listened to and valued. We would also aim to have conveniently timed sessions, which (as far as possible) occur at the same day and time each week.

On the reverse side of the ESQ, there are three questions, with free-text boxes, so service users can give more detailed answers. These questions give the person completing it a bit more space to share their views and opinions, without the restrictions of a tick box. All of the families that completed an ESQ did answer at least one of the questions on the reverse, with only one family answering each of the three questions. I will now mention some of the comments which were given in response to these questions.

Question 1) What was really good about your care?

- *'learning about stuff that I may not have noticed with my son..'* (Scott's mother)
- *'looking forward to hearing action plan/next steps'* (Harry's mother)
- *'very supportive and understanding, felt listened to, sympathetic'* (Bella's mother)

- *‘very good understanding of my child and myself’* (Leila’s mother)

Question 2) Was there anything you didn’t like or anything that needs improving?

- *‘colouring pencils need sharpening in the waiting room and blackboards cleaning – upset Bella not being able to use them’* (Bella’s mother)
- *‘children were behaved, maybe worth home visit incorporated’* (Harry’s mother)

Question 3) Is there anything else you want to tell us about the service you received?

- *‘it was easy to talk and feel listened to but just a bit difficult sometimes with my son present’* (Scott’s mother)
- *‘good. All parties school, nursery etc. talking to one another’ (Harry’s mother)*

Looking at these answers is interesting, when considering the findings from the other areas of the project – the session material, the interviews and the goals. It seems from these answers that the parents felt supported and understood during the research project, and more able to think and learn about different parts of their child and themselves. Leila’s mother’s answer to question 1 is really helpful when we think about the nature of this work, because she acknowledges that the focus of the sessions has been on Leila, but also herself too. Harry’s mother’s answer to question 1 is also important, because it links to the earlier findings regarding a wish for more. It was very clear that Harry’s mother felt that the five sessions had not been enough, and she was, therefore, keen to find out more about the on-going plan.

There were only two responses given to question 2, and as you can see, they address quite different ideas. Harry’s mother’s comment links to the previously explored idea that I had not seen everything. She felt concerned that the boys’ presentation in the clinic was not representative of their usual behaviour and perhaps, therefore, this meant I had missed something.

Bella’s mother’s comment is very different, referring to the clinic’s equipment. It was, very important, nonetheless, because the aim of this research project was to think about conducting parent-child work in a CAMHS clinic, where this work does not usually take place. Bella’s mother’s feedback informed us that the set-up of the clinic and the provisions in the waiting room could be disappointing and frustrating for young children and their parents, something which I shared with management.

Finally, question 3 received two responses. Scott’s mother raised a valid point, regarding how easy, or appropriate, it was to talk about certain topics in front of Scott. This was something which, although not mentioned by the other parents in the ESQ did feature in the therapeutic sessions and did, on occasions, require me to make separate follow-up telephone calls to parents. Harry’s mother’s comment again links to one of the themes from the clinical data, regarding network liaison and communication. Harry’s mother found this helpful and, I think that she and the other parents felt comforted knowing that the relevant professionals were talking together about how best to support the children, and indeed the families.

In conclusion, the findings gathered from the interviews, goals and ESQ helped to build a more detailed picture of the presenting difficulties, family functioning and parental understanding of their children. There was, generally, a clear correlation between the findings in this chapter, and the findings in Part A. Similar themes emerged, including ideas about who the patient was, the nature of the work, thoughts about physicality and emotional expression, and a wish for on-going support. Perhaps one of the most interesting findings from this chapter was how the parents’ answers during the post-treatment interview seemed to reflect an increased capacity to consider their children within the context of the family and the relationships between child and parent(s), rather than seeing the children in isolation. This fits with the aims of this treatment method, and I will return to this, in terms of the implications for future research or clinical interventions, within the conclusions chapter.

iv. Team presentations

As outlined in the methodology chapter, I gave two short presentation to my colleagues about the pilot and work with under-fives. I will provide a brief summary of the areas of discussion, following these presentations.

First presentation

The first presentation took place in May 2018, at which point I was in liaison with one family, but I had not recruited any other participants. In this team meeting there were fifteen members of staff present. My notes from this presentation are brief, because the discussions were limited. I think this was in part because of time restrictions during the meeting and having to manage other agenda items; however, I also observed colleagues having very little to say or ask, which may have linked to their understanding of, or interest in this kind of working.

I was asked a few questions, such as “Will the sessions be videoed?”, or “Can a fostered child be referred?”. Interestingly, I was also asked, “How do the screening team refer to you” (by a member of the screening team) despite me having sent several emails previously, clearly explaining the referral process.

There was also some brief discussion regarding the possibility of creating an ‘Under-Fives Clinical Pathway’ and there was talk of revisiting the existing Pathways to see how we meet the needs of younger children. As I mentioned previously, both the existing clinical pathways used in the clinic and the NICE guidelines (NG26, 2020) advised that long term (over a year) parent-child psychotherapy could be considered for children with attachment difficulties, when there were significant concerns about them being at risk of maltreatment. There was not, however, any reference to shorter term psychotherapy, such as that being offered in my project. Discussions with my team involved thinking about the different kinds of interventions that could be offered to younger children.

The feedback was largely positive about the prospect of my project; however, there was not very much discussion in general. I did not feel that the presentation or the topic particularly caught the team's (as a whole) imagination or interest, which I recall having felt a little disappointed about.

Second presentation

The second, follow-up, presentation took place in April 2019, and was attended by twenty-six members of the team. This presentation had a much larger staff turnout, which was coincidental, as the staff team did not know, on either occasion, that I would be presenting. There was also much more discussion following my presentation. It could be said that this was because of the larger audience, but I think it was more than this. The team seemed engaged and interested in the topic and there followed a lively discussion about both my project and work with under-fives generally. There are various possibilities in terms of an explanation for this, but I think (perhaps rather hopefully!) that it represented a changing culture and interest in infant (and young child) mental health, both in the team and, perhaps, society more generally. I shall now summarise the main points discussed.

First, there were, as in the first presentation, questions about the practicalities of the project. Interestingly, the same question was asked regarding the use of video cameras. I was also asked whether sessions could have taken place at the family home and what exactly happened during the sessions themselves.

Second, there was discussion regarding the term ‘early intervention’, which I had included when referring to the planning stages of my project and my initial ideas for the proposal. A distinction was made between early intervention meaning low-level difficulties, and early intervention meaning work with younger children. It was acknowledged that the two were not the same, and, from my brief summaries of the cases, the team agreed that although the children were young, there were very complex presentations and dynamics with which to work.

Third, we thought about our service and the fact we are commissioned to work with 0-18 year olds but the majority of our work involves the older age group. Managers highlighted that risk (e.g. self-harm in adolescents) always ‘trumps’ other presenting difficulties. This felt somewhat disheartening, however, I was able to present a view that if support is not offered to younger children, we are likely to still see these patients, but just when they are older and the difficulties are more entrenched.

Fourth, a colleague (a family therapist) reflected on her experience of working with Bella, following my referral for family therapy. My colleague described my project as having been a good piece of preparatory work, which meant that the family therapy could ‘get going’ immediately. She also praised the short-term, focused nature of my work, which had led to the family therapist’s also offering a time limited intervention, prior to the family being ready for discharge.

Finally, there was a discussion regarding the changing focus of mental health services, and an increased recognition of the need for provisions for young children. An Infant Mental Health conference taking place locally was discussed, linking to an increased impetus at national level and an attempt to engage multidisciplinary professionals in the development of services. I think this is interesting when we consider my findings regarding the importance of professional liaison and consultation. It seems that a very important area of this work, both at my project level and more broadly, is multi-agency collaboration.

The conversation was clearly lively and fruitful, and the team was interested in my project and how this kind of work could be used in the future. I was very pleased with the outcomes of this discussion and found it reassuring to hear people’s genuine interest in the topic.

Having explored the themes and findings derived from the data, the final chapter will give some concluding thoughts, bringing together the two findings chapters, as well as more general thoughts about the project as a whole. The concluding chapter will include some of my reflections on the project; thoughts about what has been learnt from the pilot and ideas about the model of brief work with children and parents more broadly, within the context of scope for service development in the current political climate within the NHS.

Conclusions

The title of this research project asks a question, ‘What can be learnt from offering therapeutic work to parents and infants (under the age of five) within a Child and Adolescent Mental Health clinic that does not routinely offer this type of intervention’? My hope was to learn about how the families experienced this treatment method, and this would be done by analysing data from the therapy sessions themselves, but also making use of outcome measures, in the form of semi-structured interviews, treatment goals and Experience of Service Questionnaires.

I began this project with the assumption that brief parent-child psychotherapy can be an effective therapeutic intervention, something which has been demonstrated within the literature (Lieberman et al, 2005; Toolan, 2003; Emanuel, 2006). I decided, therefore, to make use of a pre-existing model of working, previously used in the Tavistock Under-Fives Service.

The aim was not to test this model’s effectiveness per se, but rather to learn whether it could be made use of within a team which did not routinely offer this kind of treatment. I hoped to understand how this kind of treatment was received by the families, and the clinic team as a whole. The outcomes are of interest both to me, as a researcher, but also for the CAMHS team generally, as there is an increasing focus on how we respond to the mental health needs of young children and infants.

I shall begin this chapter by giving a summary of the data gathered; I will then go on to share some of my personal reflections from the project, before thinking generally about what conclusions can be learnt from this project, both as a one-off pilot, but also in terms of the potential implications for future research and service development.

i. The data gathered

The findings were separated into two chapters, one looking at the data from the therapy sessions themselves, whilst the other focused on the outcome measures used.

In the first findings chapter (part A), I explored six themes derived from the clinical data. These themes were diverse in their nature and related to the content of the sessions, the child's presentation and ideas about expression, communication and relationships.

One of the themes that emerged from the data related to who the patient was, during the project. Despite approaching the work with Balbernie's (1998) idea that it is the '*relationship* that is the "patient"' (p. 19), it was, at times, difficult to keep this as my focus and it was evident that 'ghosts' from the parents' pasts (Fraiberg et al, 1975) were at play in their current relationships with their child(ren). For example, Harry's mother's own experiences and mental health difficulties seemed to permeate both the work, and her understanding of him. Furthermore, as the sessions with Bella's family progressed, Bella's father's experiences and difficulties, including in relation to his own father, seemed to emerge, bringing to mind Daws' (1985) idea that parents may find themselves struggling during parenthood, despite having appeared to be relatively well adjusted and trouble-free previously.

Whilst the work was aimed at both the child and the parent, I had to hold in mind that the child was the referred 'patient'. Some of the parents involved seemed to enter into the work with an idea that the child was the sole focus; for example, Amy's mother apologising for 'interrupting' my work with Amy, or Harry's mother showing some frustration when I referred to her life experiences and how they might have an impact on the present situation, with Harry. Whilst the use of my counter-transference proved helpful throughout this project, as with any kind of therapeutic work, I was mindful about how I responded to the transference (and my counter-transference) within the sessions. Edwards and Maltby (1989) described the '*enormous and unwieldy load'* (p. 119) which the transference relationship can bring to parent-child work, especially that of a brief nature. During the project, I found myself returning to Miller's (1992) idea that the '*Parents are here on their child's ticket'* (p. 21), so whilst we can try to keep a dual-focus, we must also tread carefully and be mindful that whilst the parents' individual presentation and psychopathology will have an impact, we only really have consent to work with this in the context of the parent-child relationship.

Thoughts about my role emerged as another theme, and I found that I did have to take a flexible and adaptable approach during the therapeutic work, which links to descriptions within the literature of the Tavistock Under-Fives service (Miller, 1992 and Emanuel, 2006). Throughout all of the themes was the application of my observational skills, which were made use of in different ways. Whilst with some of the families, there were moments when the parent(s) and I observed the child together, in other cases, I took time to observe the parent-child's relationship and interactions. It was evident through the literature that observation plays a key part in parent-child work; which was also clear in my project. I found these observations helpful in terms of my thinking and processing, and I could also reflect upon them with the parents; furthermore, the sharing of my observations with the network emerged as one of the most interesting and, potentially helpful, findings from the project.

Another interesting theme to emerge related to change and transitions, something which I have thought about in several ways in relation to this project. In the literature, there is there is a broad acknowledgement that change can occur quickly, when offering brief work to young children and their parents (Hopkins, 1992; Miller, 1992; Pozzi and Tydeman, 2005), and this was reflected in the changes which emerged from the clinical data, as well as the pre and post treatment interviews and the goals. Generally, by the end of the therapy, there was more thinking about the child in the context of the parent-child relationship and the family more broadly. It was clear that significant changes had occurred in the lives of all the children and this was something I spent time thinking about with the parents.

The use of the body, and physical expression and experiences also emerged from the clinical data and featured in several of the themes, alongside thoughts about containment, safety and security. In the early literature, including Klein's contributions to our understanding of the early parent-child relationship and Bion's ideas about containment, there is the recognition of the young child's need for a parent who is physically and emotionally available in order to help the child flourish, tolerate discomfort and develop a healthy sense of identity. In my project, all the parents talked about their child's aggression and uncontained behaviour, and I saw examples of parents finding it hard to physically respond to and comfort their child, and times during which the parents own needs dominated those of their child's. Physicality and the use of the body seemed significant, which I think links to the age group involved, as well as some of the difficulties the family members had expressing their thoughts and feelings in non-physical ways.

Another theme involved the want for more, from both the parents and children, as well as from me. One interpretation of this 'want' is that the families found the work helpful, in some way, and they wanted more support. In the literature review, I summarised some of the different and varying applications of brief parent-child work, both in this country (in different settings) and globally. This want for more, and the associated comments in the outcome measures, suggest that this model of working was successfully integrated into the CAMHS team, during this project, which is encouraging for future applications of such models. I have thought about this want in terms of the families, but also myself, and how I would like to be able to continue to offer such interventions, in the future.

The nature of these themes is interesting, because I think it links to some of the core considerations when working with parents and young children together, as demonstrated within the literature; whereby the focus moves between the child, the parents, and the family, but always returning to the child. The themes seem to capture something of the child and how they were responding or functioning; but alongside this we also hold in mind the parents and their relationship with their child, and with me. We consider the child’s presentation in its own right, but also as representing something of the family’s functioning and wellbeing as a whole.

The themes have highlighted the most salient topics which arose during the work with these families, and whilst the small sample size limits the ability to generalise this more broadly, it could be said that the themes have given us an insight into the kinds of topics which may arise during work with this age group.

The second findings chapter (part B) summarised the data gathered from the semi-structured interviews, the treatment goals set by the families and the Experience of Service Questionnaires (ESQ) completed at the end of the intervention. These more standardized outcome measures indicated change in the parents’ views and understanding of their child’s difficulties during the course of the intervention. There were overlaps between the outcome measure data and the information which emerged during the therapy sessions themselves, particularly in relation to the reasons for seeking help and current concerns within the parents.

As mentioned in my methodology chapter, I had intended to offer a follow up appointment or telephone conversation with each of the families six months after the completion of the intervention; however, this did not take place. In part this was because the timeline of the whole project was longer than planned, because the recruitment process taking longer than anticipated.

Furthermore, when I planned this project, I had thought that at the end of the intervention I would end my clinical involvement with the families, and the follow-up would, therefore, be a one-off contact, following a period of six months. In reality, I was still in contact with all of the families, post-treatment, and whilst this was not clinical (i.e. I was not offering further therapy, as this was beyond the remit of the project) I did remain the children's care co-ordinator within the service, which meant on-going liaison with the families and professionals involved. It did not, therefore, feel appropriate to offer a follow up review meeting, because my role (as researcher) was somewhat compromised by my on-going role as care co-ordinator. I will say more about why I was not able to sign post and/or send the families back to the referrer as I had anticipated further on in this chapter.

I will provide an overview of what happened to each of the families, following my clinical interventions, in the postscript chapter.

I will now share some of my reflections of the project as a whole, as the researcher and the clinician. During this next section I reflect on my notes, records and memories of the project.

ii. Some personal reflections

My research journal, as mentioned previously, was a book in which I recorded thoughts, ideas and reflections throughout this project. Some of these notes were reminders of things I needed to do, or advice from supervision; but other notes centred on my feelings and experiences. I found it helpful to record these notes as a way of trying to process and make sense of things.

I included an extract from my journal in the methodology chapter, in which I referred to my project as being like my 'baby'. I had the experience of waiting during the recruitment process, with a sense of anticipation, whilst wondering what things would look like in reality. I think this could be said to, in some senses, link to a mother's experience of waiting during pregnancy, with perhaps both feelings of excitement but also apprehension.

Throughout the project I experienced feeling worried, apprehensive, excited, committed and fearful; questions about whether I was doing things 'right' and, at times, I wished for a co-researcher (or 'co-parent'). I also experienced a sense of humiliation at times, during the clinical interventions, when the children would leave the room, make noise in the corridor, and with one patient, there was the repeated occurrence of the corridor being intentionally flooded. I recorded in my journal that, at the times, colleagues walked past me, whilst I was mopping up the water on the carpet, and rolled their eyes or gave a little laugh, rather than offering some assistance. I did, therefore, feel alone with the 'mess' which, I think again mirrored how the parents felt, at times, especially when their child was 'playing up' in public.

My counter-transference, during this project, was, therefore, important in terms of helping me to better understand something of the parents' (and the children's) experiences and whilst I found these feelings uncomfortable, they helped me to focus on what the child was expressing and how the parents were left feeling, as a result.

I wrote a long entry in my journal, following my post-treatment telephone review with Amy's mother. In this call, Amy's mother disagreed with several of my comments, appearing defensive and unhappy. The following comes from that entry:

> *I felt annoyed, not listened to and rubbished – but also confused. Today she had contradicted things that we had previously discussed, told me I had not done enough (despite me having recently had in depth discussions with two adoption specialists) and disputed my view ... I thought about my confusion, my powerlessness and my feelings about being told I am incorrect. I also noticed my strong feelings of anger (I found myself wanting to slam the telephone down, although of course I managed to contain these feelings!) – these all seemed to link to Amy's presentation* (25th September 2018)

What was particularly interesting for me was that I found myself put in touch with both Amy's experiences and her mother's, which was quite complicated. Amy's mother felt disappointed in me, let down and that I was not what she had hoped for, which I think captured something of how she could sometimes feel towards Amy. Furthermore, in the way that my intervention was not 'enough' for Amy's mother, I think she could feel she was not enough for Amy too; this was mentioned in Mother's answer to question two of the post-intervention interviews.

Another element which I reflected on during this project was the limitation of brief work. What follows is another extract from my journal, written when I was midway through the interventions with most of the families:

> *I have been having thoughts about not giving the families the right thing, or not having the answers or strategies that they want. I have had some thoughts about the limitations of this model, for these kind of cases, and I feel that most (if not all) of these families would need many more than five sessions to really make a difference* (29th August 2018)

I felt troubled by the limitations of my project, and I think my journal entry captures one of the key findings from this project; that five sessions may not be ‘enough’ in such complex cases.

In my proposal, I had stated that if the children (or families) needed on-going support, following the intervention, I would communicate this need to the referrer, and would ensure that the families continued to receive treatment as usual or, if required, a referral be made to another relevant service. Looking back at this now, I can see a clear flaw in this mention of ‘treatment as usual’, because within the team there was not a routine offer of treatment for children of this age group, and realistically, these children may not have been accepted into our service, had my project not been running. The lack of provisions locally also meant that signposting on was not necessarily possible. Once the families had been ‘taken up’ by the service, it would have been difficult (and perhaps, it could be said, not ethical) to discharge them as soon as the intervention had ended, even though there was not the scope for further work with me. This highlights one of my central considerations during this project, trying to manage being both the researcher and the clinician. I think having a fellow researcher or designated colleague to take over as care co-ordinator once my project had finished might have been beneficial. I will say more about this later on.

Some of these families felt that CAMHS was their last hope and some had been waiting a long time for support. It was, therefore, a delicate task trying to manage the parental expectations, my recommendations and the available provisions. These observations do link with work in CAMHS generally; where short-term interventions are often favoured, and there is often, unfortunately, a drive for discharging service users relatively quickly, even those with complex difficulties. There is, at times, a lack of resources available which can lead to frustration in service users and clinicians alike. As psychotherapists, we are primarily trained in offering longer-term therapy; however, our skills can also effectively be utilised in short-term models as well (Harris and Carr, 1966). When using a brief model of therapeutic intervention the tasks of time management, identifying a clear focus and holding the ending in mind are all paramount, as well having to bare the possible limitations of shorter term work.

My experience of finding it hard to end, as well as evidence from the clinical data, was indicative of the on-going needs within the families, and it was clear that five sessions, in isolation, was not necessarily enough. The difficulties present in the children were often complex and severe and, although they were young, this did not mean the damage could be easily or quickly repaired. It may have been that some of the families would have been better suited to a longer-term intervention; however, it is also important to consider that whilst some of the difficulties could be alleviated (by either short or long term support), it may not be possible to entirely repair or ‘cure’ them. As I have mentioned previously, the needs or difficulties of young children are often considered as low-level; however, this is not the case and as my project has demonstrated, even the child’s very earliest experiences can have a long-lasting and far-reaching impacts.

Whilst my exclusion criteria had aimed to avoid recruiting parents with severe mental health difficulties, some of the parents involved were struggling with their own mental health, and this did, I believe, impact on the effectiveness of the work, to an extent. Harry's mother, for example, was pre-occupied with the idea that Harry needed a diagnosis, and many of his behaviours or difficulties were quickly attributed to this. I think Harry's mother's own psychopathology affected her understanding of and responses to Harry's behaviour and communication and it was challenging to think with her about this. It can be hard to work with parents when the adult part of them is difficult to access, and this adds to the complexity of this kind of work.

This finding, regarding the complexity of cases, correlates with Toolan's (2003) observations following the development of a parent-infant service in the North-East of England. Toolan referred to the high prevalence of complex cases within the children referred to the project, despite the service aiming to offer early and brief intervention only. It is suggested that the severity of difficulties may not be fully recognisable at the point of referral, furthermore, '*Questions are raised, however, about how difficult it is for people to bear holding the infant and parents in mind where major difficulties and distress are emerging'* (p. 69). This seems to correlate with an idea that difficulties with younger children are often deemed to be low-level, or straightforward in their nature; however, as Toolan, amongst others, and I found, this is far from the truth. It can be difficult and painful to think about disturbances and distress in young children.

I was, however, able to signpost some of the families onto other local services or support, such as a post-adoption service, and ELSA support within school. One of the families was also referred on for family therapy within the CAMHS team. Therefore, whilst further parent-child therapy was not available, and not necessarily needed by all of the families, I was able to offer some signposting which I believed would be beneficial for the children, parents or the families as a whole.

iii. What can be learnt from this project?

In terms of participant recruitment and engagement, all of the families that were approached gave their consent to participate in the project and there was no participant attrition (with the exception of one ESQ not being returned). The ESQ's received generally positive feedback and the parents described feeling listened to and supported, and they felt it was helpful to have sessions with someone trained and with a good level of understanding.

Thinking back to the findings chapters, in particular the pre and post treatment interviews, change in the parents' thinking and the parent-child relationship was evident. I thought the shift away from focusing mainly on the child's behaviour was important as it demonstrated the parents' ability to try to understand and think about what the behaviour might be communicating and *why* it might be present. Another important development (at post-treatment interview) was the increased focus on the family, and the parent-child relationship; rather than primarily focusing on the child in isolation. Alongside this was also a growing acknowledgement of the parents' own difficulties and feelings, alongside those of their child.

This brings to mind Lieberman's (2004[b]) idea that parent-child psychotherapy focuses on developing a shared meaning and relationship between the parent and child; whereas parent-infant psychotherapy focuses more on the child's developing agency and the impact of the parents' own childhood experiences. I think, looking back at my data, Lieberman's distinction feels salient, as the sessions did involve thoughts about what the child might be communicating and how the parents might helpfully make sense of this, within the context of their relationship, and there was perhaps less thinking about the parents' own childhood experiences or relationships with their parents than I had anticipated (following reading literature in this field).

It has been interesting for me to think about the difference between parent-infant and parent-child psychotherapy. When I planned this project, I aimed to recruit children under the age of five, so this could have, in theory, been infants or children. I think I anticipated that work with this age group would follow the same principles in general; however, having read about other people's work and carried out my own intervention, there are clearly some significant differences between the focus of work with parents and infants and work with parents and children, as highlighted by Lieberman (2004). It would have been interesting if the age range of the children involved in the project had varied more, so I could have had the opportunity to work with parents and babies, as well as parents and slightly older children. However, it would have been unusual for young infants to be referred into the CAMHS team, so involving infants in the project would have meant using a different recruitment method.

We could perhaps summarise the focus of the sessions of all the families, in general, as being what it meant for them to *become* a family. Each family had a different make up and different ways of relating but throughout the data with each family there was reference to the birth or arrival of their child and how this change was accommodated and responded to. As the intervention progressed, there was more talk of the needs, the strengths and the difficulties of each of the individual family members, as well as increased thought about the family as a whole.

At the beginning of the interventions I felt, with some of the families, that I was working with the parents, in the presence of the child; whilst with others it seemed like the opposite. It was not always as easy to work with both together, in the way which I perhaps assumed I would be able to. It seemed that there were several factors affecting my ability to hold both the parent(s) and the child in mind. First, as I have mentioned previously, some of the parents' own difficulties seemed far more concerning and pressing than those of their children. Second, with some of the families, I experienced the parents not really wanting to take an active role, and rather, it seemed, hoping that I would attend to their child, in isolation. Finally, brief work with parents and children together was something which I did not have vast experience of, prior to the project, so I found myself learning about and understanding this way of working as the pilot took place. Looking back, there were probably times that I could have taken a more directive, perhaps paternal role, during the sessions. I did find, however, that the task of holding both parent(s) and child in focus became more possible as the interventions progressed.

If I were to conduct the study again, I think it might be beneficial to carry out one or two of sessions with the parents alone, especially perhaps the first meeting. This would allow us to discuss more sensitive and perhaps complex topics, which may not be suitable to share with a child. I think it would also be beneficial to be able to think more with the parents about this way of working, which would perhaps help with managing some of the expectations and thoughts about who is the patient (as mentioned in findings – part A). Whilst the brief model of intervention developed at the Tavistock Clinic did generally involve both parent(s) and child in each session, in the literature there are references to times when, during therapeutic interventions based on this model, it might be appropriate or necessary to see parents alone for one or some sessions (Edwards and Maltby, 1989; Emanuel and Bradley, 2008).

In hindsight, I think I was trying to follow the ‘traditional’ model of brief parent-child psychotherapy, and I did, therefore, feel that I needed to include the children in all five therapy sessions. Interestingly, when I have carried out brief parent-child work, outside of this project, I have often suggested seeing the parents individually as part of this intervention. I have wondered if I, by trying to implement the pre-existing and well documented Tavistock model as part of a research project, somehow lost some creativity in my own clinical approach, and, curiously, some of the ‘*Flexibility, promptness, and informality’* (Miller, 1992:19) which were said to characterise the Tavistock Under-Fives service. Perhaps the flexibility which Miller referred to may not have been entirely compatible with a research project, in which I wanted to offer participants a standardized (and, therefore, comparable) treatment model, where all of the families received the same amount of sessions, using the same therapeutic approach, as far as possible. I did, however, try to hold on to the ability to be thoughtful and curious, something which also seemed to be at the heart of the Tavistock model.

Besides wanting to learn about how the families involved experienced this kind of work, I also wanted to learn about how the clinic team responded to the project taking place because the service does not routinely offer therapeutic work for this younger age group. As I have mentioned, there was an overarching theme in the data relating to what it meant for the participants to become a family. Through the sessions, I experienced the families responding in different ways to becoming involved in the project, and to my arrival in their lives, and the ideas I had to offer. Furthermore, the project itself represented the birth of something new and different in the team, and I wanted to learn about how my colleagues responded to its arrival. Ideas about adaptation, understanding and curiosity seemed relevant to both the clinical data and to the pilot study more broadly.

I have already given a summary of the topics stemming from my two presentations to the team (see findings – part B). It was clear that there was, particularly in the second presentation, interest in this kind of work and the team engaged in lively conversation about not only my project design but work more generally with this age group. At the end of my PowerPoint presentation, before the discussion began, I posed some questions to the team, which I thought might help to open up discussions. These questions included, ‘Were you aware the project was taking place?’ and ‘What is it like to have under-fives in the clinic?’, I also asked other questions about how the team see their role in relation to infant mental health.

Interestingly, amongst the discussions which followed, there was limited direct feedback about how the team experienced my pilot project, in practice. I am not sure how to interpret this, one possibility is that my colleagues did not know that the project had taken place; although I know that some of the team had certainly been aware. As I have mentioned previously, there were some quite interesting responses from them, whilst the sessions took place; for example, when the corridor had been flooded by Scott. Another possibility is that my colleagues did not want to share their thoughts about the project, or they did not know what to say. I certainly experienced some colleagues appearing quite distanced from the discussions, as though this kind work (with young children) was not part of their remit or not something they felt confident or knowledgeable in - which I believe highlights some of the barriers in establishing routine work with under-fives.

It is perhaps important to note that no administrators attend the team meetings, so they were not part of my presentations or the discussions. I have, however, previously mentioned how there were some comments made during the project, by these staff members, such as asking me to see families earlier or rolling their eyes upon a family’s arrival. I wrote in my research journal about this, questioning, *'How do little children find their place in our clinic (which is supposed to cater for 0-18 year olds)?'* (July, 2018). I think these responses from the admin team linked to an idea that these younger children, with their loud liveliness and unpredictability, somehow disrupted the waiting room equilibrium, and their volume, their play and their uncontained nature felt messy. There was, perhaps, a worry related to being confronted by disturbances in younger children, something which can feel intolerable and unbearable, and which may highlight the high level of projections from young children, that are so powerfully felt by those adults around them.

I now wonder if it might have been helpful to meet with the administrators as well, in order to explain my project in more detail and to give information about why the project was being run and what I was hoping to learn. Edwards and Maltby (1989) made specific reference to the important role that their secretary played, in their project, in terms of offering telephone liaison to families and typing up the session material. I may have been able to think with the admin team about the work, which in turn may have led to them taking a more supportive role during the project.

It may have also been helpful to attend another health visitor team meeting, in order to share reflections on the project. This could have enabled me to gather some feedback from those health visitors who were directly involved with families who participated in the project. Also, there may have been value in speaking to some of the health visitors who did not refer potentially eligible families, in order to explore some of the potential barriers for referral.

I will now discuss some of the limitations as well as the strengths of this research project, beginning with the limitations. The small sample size means that the results from the project are not widely generalizable. We cannot reliably apply the findings to brief models of parent-child psychotherapy in other clinics, or to a wider sample; however, they do allow some conclusions to be drawn about how the specific families involved received the intervention, which was my aim. A further limitation was the time-limited nature of the intervention, which meant that on-going therapeutic work was not possible, despite a recognition by both the families and me, that further work may have been beneficial. Although I remained involved with the families (as care co-ordinator), I was clear to follow the boundaries of the project and I did not offer any more than the scheduled five therapy sessions.

It may have been that offering the five sessions, with an optional additional five sessions, could have been helpful, as per the model originally used within the Tavistock Under-Fives Service (Emanuel, 2011). However, owing to the limitations of this project and me being both the sole researcher and the therapist, I decided not to offer the additional sessions, as I felt that this would take up more time than I could allow and it would generate more data than I would realistically be able to analyse.

Whilst I found the time-limited nature of the project both challenging and restrictive at times, discussions during supervision helped me to reframe the parameters of my project in my mind, and led me to consider that my intervention could function as an extended assessment, rather than only a standalone piece of therapy. I found this idea helpful and, certainly after the clinical interventions were over, I was able to use the sessions to provide a detailed and thoughtful picture of the families to the network, which was helpful in informing future support and professional understanding.

Emanuel (2011) stated, in reference to the Tavistock Under-Fives service:

> *There are occasions when an initial piece of brief work may bring about change, but also may function as an assessment for, or result in, long-term family work, individual psychotherapy treatment for parent or child, or parent–couple work. It is often difficult to ascertain from the initial referral the level of severity of the problem and the nature of the intervention that may be required.* (p. 673)

It would seem, therefore, that the findings from my research project mirror a finding from this kind of work more generally. Whilst brief parent-child work may not entirely 'resolve' the presenting issues, it can still have a therapeutic impact and the thinking done within the sessions can be used to inform on-going treatment options and service provision.

I will now summarise some of the strengths of this project, the main one being that the pilot offered the families a treatment method which would not have otherwise been routinely offered within the service, and which was generally well engaged with and well received. The clinical sessions encouraged the parents to think about their children within the context of the parent-child relationship (or more widely, within the context of the family) and at the post-treatment interviews there was more recognition of the role that the parents play and how they are able to help support their children.

This project also led to thoughtful discussions within the team, regarding provisions for infant mental health, and fitted in with a movement (within the service and the Trust) to try and consider the needs of this age group and how we may be able to develop services to better meet the needs of these young children and their parents.

Another key finding and something that could be described as a strength of this way of working generally was the role that professional liaison and consultation played. As I have mentioned previously, I was surprised by how much contact I had with other professionals involved, including; health visitors, nursery staff, school staff and family support practitioners. This liaison included attending meetings, writing reports and sharing my thoughts about the child (and parents) in terms of additional support required. In my research journal I wrote:

> *I have noticed how much network liaison has been involved in the work so far, on average I am receiving one call a week, asking for updates or further information … I was asked to send two reports in the first five weeks of having met the family, thus indicating the levels of worry and concern in the network. In general, it seems that the networks are much more involved and engaged with this young age group, which is helpful* (11th July 2018)

This entry was written when I was just about to finish with the first family, but I had not yet begun with any other families. My observations about the level of professional liaison with this first family went on to be mirrored within the other families too. This wish for communication and liaison between professionals, I think, indicated the high levels of anxiety regarding these young children (and their families) and also a wish to think together and address the difficulties from a multi-agency perspective. This is interesting for me to consider in terms of other age groups, because often, particularly with adolescents, there can be a push from other services for CAMHS to address the issues, rather than there being more joined up thinking between professionals.

Furthermore, liaison and consultation with other professionals is a key part of a psychotherapist's role within a team, and I believe there is something very important about trying to make a space to 'think' together about families. One example that comes to mind, from the project, involved Amy's family. I referred Amy's parents to a local post-adoption charity, and a few months later I was contacted by the allocated social worker. We had a lengthy telephone call, for which the social worker was grateful, as I was able to share my experiences of working with the family and what I understood of the dynamics and relationships at play.

It is clear, therefore, that one of the benefits of this kind of working is the ability for the therapist to feedback and share their ‘findings’ with the network. I certainly found that the other professionals involved were willing to think and talk together. I had not anticipated that this would be such a predominant outcome of this work, but it is something which could certainly be made use of in future work with this age group.

In my introduction, I referred to the ACP ‘Child psychotherapy in the early years briefing paper’, which highlighted three areas of work carried out by psychotherapists; assessment, therapeutic intervention and consultation. It could be suggested, therefore, that my intervention involved elements of all three of these categories; offering both therapeutic work, and also a kind of extended assessment, both of which involved consultation with other professionals throughout. In the preface to the ‘What can the matter be?’ book (Emanuel and Bradley, 2008), the role of consultation, in the Tavistock Under-Fives Service was highlighted, so again it seems like my pilot project correlated with the findings from the Tavistock’s service. Brief work with under-fives is, it could be suggested, a careful combination of therapeutic input to the families directly, and consultation with other professionals.

I will now say something about level of complexity present within these children and their families. I believe that there can, at times, be an idea that younger children will be more straightforward to work with. This links with the ideas in the literature about the problems being less engrained and there being a scope for change (Pozzi and Tydeman, 2005; Rustin and Emanuel, 2010). However, I think we must also be careful not to underestimate the level of need and complexity which can be present in young children, especially when we are thinking about both them and their parents (or families).

Within my sample there were difficulties relating to domestic violence, sensory processing, parental mental health, finances, parental separation and adoption – to name a few. I believe that it was helpful for me and my colleagues to gain a better understanding about the kinds of difficulties which affect young children, so we could think further about what support we are able to offer. A strength of this project was, therefore, capturing detailed information about some of the presenting difficulties affecting children under the age of five, as well as in their parents and families.

This links with the afore mentioned discussions within my second presentation to my team, regarding the idea of ‘early intervention’ and what this can encompass when we are considering the younger age group. In terms of areas for future exploration, it would be interesting to gather further data regarding the main presenting difficulties within this age group.

In summary, I think the pilot project was successful and it enabled me to learn a lot about how this method of working is received by families, some of the strengths and limitations of this model and how it is received by fellow staff members. It was clear that the brief nature of the work was somewhat of a limitation; however, the high prevalence of professional liaison and consultation stemming from the sessions meant that the work had a distinct value both in terms of what occurred within the sessions, but also in terms of onward thinking regarding future input and the needs within the family.

I will now go on to share some concluding thoughts regarding the potential implications of this project for the future, in terms of service development and Government agendas.

iv. Implications for the future

Something I hear a lot, working within the NHS, is the focus on short-term interventions, rather than open-ended, long-term work. There is clearly a financial driver behind this, but also a link to the intense pressure staff are under because of the sheer number of referrals – in summary, short-term interventions mean that staff members can see more patients. Traditional individual psychotherapy is, perhaps, seen as the opposite to this, as often the work is not time limited and children can be seen once or more a week, sometimes lasting for several years. Concerns can be raised about how long one child is engaged in therapy and the implications this has on the staff member’s time, and ability to see other patients.

It could be suggested that the brief model of parent-child psychotherapy used within this pilot may, therefore, carry more favour within the current NHS working climate. The drive for evidence-based and short-term interventions has been documented within the literature (Rustin and Emanuel, 2010; Rustin, 2003) and this project (and method of working) did respond to both of these needs. When we think about the realities around how we offer a service to under-fives, something like a brief model of intervention, may be a practical solution. I have previously highlighted the limitations of the time limited nature of the project, and how there was, generally, a recognition that all of the families required some form of on-going work; however, I think it is important to think about what was and can be achieved using such a model.

I have referred to the need for ‘on-going work’ within the families involved in the project, but I want to be clear that this did not necessarily mean long-term individual therapy, but in reality me attending two or three meetings, or me referring a family on for family therapy, for example. Brief parent-child psychotherapy would, for some presenting difficulties, be a sufficient intervention in its own right; however, for complex difficulties (such as within this project) the parent-child work may function as one part of an intervention, within a multiagency approach.

My findings seem to correlate with reflections in the literature regarding the need for flexibility and the acknowledgement that brief parent-child work will not be suitable for every case (Barrows, 2003; Pozzi, 2003). I have previously mentioned how helpful and informative I had found the book *“What can the matter be?”: Therapeutic interventions with parents, infants and young children (*edited by Emanuel and Bradley, 2008). In the book’s introduction, the reader is told that the Tavistock’s Under-Fives service did expand to incorporate longer-term therapeutic work, based on the complexity of referrals and the vital need for multiagency liaison. Again, this seems relevant to my findings and is important when considering under-fives work generally, and how we respond to and support the mental health of young children and their families.

As highlighted in the discussions following my second presentation to the team, there is something of a cultural shift beginning, which means that more of a spotlight is being put on infant mental health and clinicians are beginning to find ways of thinking and talking about this subject more. It is important that psychotherapists, with their training in infant observation and work with both young children and parents, contribute to these developments, as they have considerable of knowledge and experience which is relevant to this field.

This project could also lead on to further areas of exploration or research, in order to continue to gather information about parent-child therapy with under-fives. I believe it would be interesting to offer a similar pilot, but with a more flexible model of working. This would not necessarily have to mean open-ended work, but perhaps the flexibility to offer, say, another five sessions, if required.

I believe that there was also scope for further consultation and liaison with the health visiting teams, especially those who were involved with families that participated in the project. They could have offered some valuable reflections on how support was received and responded to by these families, and whether there was any additional therapeutic input which might be helpful. As previously mentioned, it would also be interesting to have two therapists present throughout the sessions. I found that trying to manage the needs, wants and communications from two parents and their child (or children) was sometimes challenging on my own. Having two therapists would have given more space to think about both the child(ren) and the parent(s) and it would have allowed for some discussion and thinking between the therapists outside the sessions. In the literature written about the Tavistock Under-Fives Service, or projects based on that model, the possibility of co-working has been explored. Emanuel and Bradley (2008), in their book's introduction, highlighted how single or co-working may be chosen, depending on the individual family and the presenting difficulties. Furthermore, the option of working alongside and making good links with colleagues from other fields has also been highlighted (Cudmore, 2007; Edwards and Maltby, 1989). From a purely research perspective, I think it would have been helpful to have had a colleague taking the role of care co-ordinator for the families as I found balancing the role of researcher and clinician difficult at times, especially, as mentioned earlier, after the project, when my role changed.

Another variation could be offering some or all the sessions within the home, as was offered by Fraiberg and colleagues (1975), or within the community, in the way the Tavistock Under-Fives Service offered, when needed (Emanuel and Bradley, 2008). Several of the parents commented on how their children's behaviour was different in the clinic, and, thus, how I did not see the full picture. Future research could incorporate offering one home visit, for example, which could help the therapist to gain a fuller picture of the relationships and interactions between the parent(s) and child.

Finally, in my introductory chapter, I referred to an audit carried out by one of the Trust's assistant psychologists, looking at the trajectory of CAMHS referrals for under-fives in one year (2015-2016). Had time allowed, I think it would have been interesting to gather an up-to-date version of this data, in order to see if and how things have changed since 2015-2016. This could be further investigated outside of this research project, and would be relevant to the on-going discussions within the service and Trust.

v. Closing thoughts

In conclusion, at the start of this project I set about trying to find out what can be learnt from offering brief parent-child psychotherapy, in a CAMHS team which does not routinely offer this kind of therapeutic intervention. In summary, a few key findings have emerged. First, this kind of intervention was well received by the families; they wanted to participate and in their ESQ feedback they described feeling listened to, well supported and understood. Second, I learnt about the important role that professional liaison and consultation plays when working with this age group. As I have suggested earlier, I think this is in part associated with the high levels of anxiety in professionals regarding mental health difficulties in children, and a wish to improve the situation; however, I also found that this professional liaison often centred around the parental needs and difficulties. I believe it was helpful to think with the network about the parental challenges and emotional states, in order to help understand the child’s presentation.

Third, I think that more flexibility in terms of the number of therapeutic sessions may have been helpful. From the goal ratings, we saw that of the eight goals set (across the families) five were rated as having improved, two stayed the same and one was said to have got worse. Although this shows a general improvement, I think with more sessions, perhaps even just a few more for each family, the goals (and the ‘effectiveness’ of the treatment) may have improved or increased.

Finally, in terms of what has been learnt about the team’s responses to the project, I would say that further exploration could have been helpful. It appeared that during the follow up presentation there was, certainly, an interest from colleagues in work with under-fives generally. I believe that further training in this area for team members could be beneficial, and continued thinking and planning about how we meet the needs of this young age group, from both a team level and a service development perspective.

I would like to end with a quote, which comes from a book that I was given whilst I was carrying out this project. The following words struck a chord with me, in terms of my project and some of the conversations and thinking which occurred during the therapy sessions. The words are describing children, and are addressed to parents:

> *You may give them your love but not your thoughts,*
> *For they have their own thoughts.*
> *You may house their bodies but not their souls,*
> *For their souls dwell in the house of tomorrow, which you cannot visit not even in your dreams.*

> *You may strive to be like them, but seek not to make them like you.*
>
> *For life goes not backward nor tarries with yesterday.*
>
> *You are the bows from which your children as living arrows are sent forth* (Gibran, 1923: 24)

I think this quote highlights some important ideas when we are considering work with young children and their parents, including separation, individuality, identity and thoughts about the past, present and future. In this thesis, I have talked about the impact which parents' early experiences can have on their ability to parent and on their own children's development and wellbeing.

I think what Gibran was addressing was an attempt to set the child free from these ties (or projections), in order to see the child as an individual with their own thoughts, feelings and desires. This also brings to mind Klein's (1936) suggestion that the mother must realise the baby is not her possession, but a separate individual, who needs to be develop independence. During this project, I experienced some of the parents wanting to control their child, or have them behave in a certain way, and I heard about the challenges of having their child enter into a phase of development in which independence, will and growth are paramount.

This change, from baby to toddler or child can be challenging, but I believe that through this kind of work a shared language can be developed. If we consider the parent as the 'bow' then we see the importance of the parents' experiences, strengths, directions and hopes; they will ultimately shape the beginning of the child's (the 'arrow') journey into life. However, we must also help parents to see that the child will have its own individual pathway, and helping the child to develop a strong sense of self is another key role of a parent.

Postscript

In this chapter, I will give a brief summary of what happened for each family after the pilot had ended.

Scott Anderson: at the end of treatment, Scott's mother felt that things had certainly improved in terms of Scott's presentation and her relationship with him. However, whilst my intervention had been running, Scott had recommenced contact with his father, and his mother believed that this contact was having a negative impact on Scott's behaviour. The Children and Family Court Advisory and Support Service (CAFCASS) were involved, so I encouraged Scott's mother to discuss her concerns with them, in order to try and make contact arrangements more structured and consistent for Scott (and his younger sibling). Interestingly, when the project began, there been a high level of professional liaison in relation to the family; however, this had significantly reduced by the end, although there were shared concerns about the contact arrangements between Scott and his father. I had also fed back to Scott's mother and the professionals involved that I believed she would benefit from some individual work. I felt that unresolved difficulties in relation to her life experiences and the domestic violence she had experienced were having an impact on her ability to parent Scott, at times; especially following Father having recommenced contact with the children.

I did not hear anything, from either the family or the professionals, for approximately two months post-pilot; but when I made contact in order to review and discuss discharging Scott from our service, I was concerned to find out that things had escalated quite significantly over the short period of time and the family was now open to Children's Social Care. It was interesting that despite the network being aware of my continued role as care co-ordinator, I had not been updated on these changes. Following this, I became more actively involved again, and began attending regular Team around the Family (TAF) meetings. I was able to share my knowledge of Scott and his mother, and offer advice regarding further support which might be helpful. Considering the current concerns about Scott's mother's mental health and on-going difficulties in relation to contact with Father, I did not feel that further therapy was suitable, but instead suggested that Scott's mother should receive increased support, and time was spent discussing how school could manage the very challenging behaviour Scott exhibiting.

My role following the research project was, I believe, to offer consultation to the network. I was able to think with the other professionals about what Scott might be communicating and what might be helpful for him; including discussions regarding applying for a place at a specialist education provision, as Scott's current school felt that his high levels of aggression, violence and unpredictable behaviour were becoming unmanageable in a mainstream provision. As it stands, my attendance at these meetings continues.

Harry Tate: the end of my therapeutic intervention with Harry and his family coincided with Harry starting school. I felt it would, therefore, be helpful for me to liaise with the new school, once he had settled in. Harry's mother had shared many concerns about how he would manage school, and she believed that further therapy was required. Harry's mother still believed that Harry had a neuro-developmental condition and she had contacted her GP, who had written to me, and the paediatrician (who had previously discharged Harry, stating that there was no evidence of a neuro-developmental condition) asking whether this needed to be investigated further.

I attended one professionals-only meeting, and a second meeting attended by Harry's mother as well. I heard that Harry's transition to school had, on the whole, gone well, although school identified that Harry could struggle with social interactions, so additional support from the pastoral team and use of the 'nurture room' had been put in place. The school recognised how well he responded to consistent and clear support from staff.

Harry's mother, however, continued to present a picture of a disturbed and troubled little boy, and she talked in the meeting about things such as Harry head-banging at night, stating that she had never received any support regarding this and she felt sure it was a sign of something more serious. I was pleased that I was present at these meetings, because I was able to talk to the network (who were, understandably, very concerned by Mother's accounts) about what these behaviours might communicate, and how Harry's parents and I had spent time, during our therapy sessions, thinking about these behaviours and how best Harry's parents might be able to respond and understand them.

I felt concerned about the levels of projections into Harry, and his mother's presentation of a boy who required a diagnosis. I was, however, reassured by how he was getting along at school, and how well he responded to the very thoughtful and consistent approach from the staff. I fed this back to the network and then discharged Harry from the CAMHS team. As part of this, I wrote a letter to his parents, school, GP and the paediatrian, explaining what support had been put in place, and how I did not believe that further screening or diagnosis was required. I also suggested that if further support were required, it would be helpful to consider some family support, working with Harry's parents.

Amy Hancock: during the therapy sessions with Amy and her parents, it was difficult to discuss things openly, because Amy did not know she was adopted and her parents were quite prescriptive about the kinds of things we could and could not discuss together. In telephone calls with Amy's mother, however, I was able to talk more directly about Amy's adoption and how this, and her very early experiences, might be having an impact on her current presentation and difficulties – something which Mother identified that she had not really appreciated previously. Based on these discussions, and my belief that being honest to Amy and her brother about their early history and their adoption would be a helpful thing, I referred Amy's parents to a post-adoption charity, requesting that the family be given some support regarding attachment and the impact of adoption on children. I also suggested that it might be helpful for Amy's school staff to be offered some consultation as well.

When the family were offered support, I rang to speak to the allocated social worker and explained a little bit about my intervention and my reasons for referral. The social worker talked at length to me about her impressions of Amy's mother and the situation, and was very grateful for our conversation. When I made contact a few months later, I heard that the service were now trying to help Amy's parents consider how they might tell their children about their adoption and the worker had also gone into Amy's school to provide some information about attachment and how they might be able to helpfully respond to Amy's difficulties in class. No further consultation with me was required, so Amy was discharged from our service.

Bella Phillips: through the therapy sessions, it emerged that there were some quite significant systemic difficulties in Bella's family, predominantly in relation to her father's mental health and life experiences, which had an impact on the way in which he related and responded to Bella. I arranged to meet with Bella's parents following the completion of the project, and shared my thoughts with them, suggesting that some family therapy might be helpful, as well as some individual mental health support for Father (which we had also discussed during the therapy sessions themselves). The family were in agreement and whilst they awaited allocation for family therapy, I met with Mother again for a review and had periodic telephone calls with the family support worker involved with the family.

I have heard from the family therapists that both parents engaged well, and after four sessions, the family were discharged from our service. Bella’s father was also actively pursuing individual support for himself.

Leila Smith: Leila’s parents (special guardians) had a fairly good understanding of how Leila’s early history might be impacting upon her currently and in the future. They were struggling with aspects of Leila’s presentation and the impact of this upon the family and their birth children; however, it seemed to me that they had quite realistic expectations and understanding. In my review with Leila’s mother, she talked about her own struggles and referred to some experiences during her childhood, including with her own mother. I was able to think with her about these, in relation to the current situation with Leila, and I did suggest that Mother might benefit from looking into some individual support for herself.

Leila’s mother and I met three times after the therapeutic intervention had finished, and I had telephone contact with Leila’s school. After these additional review appointments, Leila’s mother and I were in agreement that no further specialist mental health support was needed for Leila at that time. Leila’s school had put in place comprehensive in-class support, which Mother thought was really helping Leila to feel safe and contained, and Mother had observed a significant decrease in the aggressive and regressed behaviours from Leila at home – both of which had been of concern to the family when they were recruited for the project.

In summary, my involvement with the families, after the research intervention had ended, did vary from family to family. For Bella and Amy, a referral for additional support was necessary; although both of these interventions were aimed predominantly at the parents. For Leila and Harry, offering a limited number of meetings and reviews was all that was required, post-treatment. Scott’s is the only one of the five families with which I am still involved; however, I see my role as offering network liaison and consultation, rather than being solely therapeutic in its nature. As I have suggested throughout the findings and conclusions of this project, I have found sharing my thoughts and understanding of the families with the network very important and several of the professionals involved have commented on how helpful this has been.

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Appendices

Appendix i

27th February 2018

Dear Rachel,

Project Title:	**What can be learnt from a pilot project offering brief therapeutic work to parents and infants in a Child and Adolescent Mental Health Service?**
Principal Investigator:	**Dr Margaret Lush**
Researcher:	**Rachel Allender**
Reference Number:	**UREC 1718 14**

I am writing to confirm the outcome of your application to the University Research Ethics Committee (UREC), which was considered by UREC on **Wednesday 15 November 2017.**

The decision made by members of the Committee is **Approved**. The Committee's response is based on the protocol described in the application form and supporting documentation. Your study has received ethical approval from the date of this letter.

Should you wish to make any changes in connection with your research project, this must be reported immediately to UREC. A Notification of Amendment form should be submitted for approval, accompanied by any additional or amended documents:

http://www.uel.ac.uk/wwwmedia/schools/graduate/documents/Notification-of-Amendment-toApproved-Ethics-App-150115.doc

Any adverse events that occur in connection with this research project must be reported immediately to UREC.

Approved Research Site

I am pleased to confirm that the approval of the proposed research applies to the following research site.

Research Site	**Principal Investigator / Local Collaborator**
[redacted]	Dr Margaret Lush

Approved Documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	**Version**	**Date**
UREC application form	2.0	20 December 2017
Participant Information sheet - Adult	2.0	20 December 2017
Consent form	1.0	20 December 2017
Assent form	1.0	20 December 2017
Letter from [redacted] – DBS check confirmation	1.0	18 October 2017
Experience of Service Questionnaire (Parent or Carer)	1.0	18 October 2017
Gatekeeper approval letter	1.0	18 October 2017
Letter to GP	1.0	18 October 2017
Participant Information Leaflet	1.0	18 October 2017
Semi-structured interview schedule	1.0	18 October 2017
Introductory information sheet for participants	1.0	18 October 2017
HRA Approval letter	1.0	22 February 2018

Approval is given on the understanding that the UEL Code of Practice in Research is adhered to.

The University will periodically audit a random sample of applications for ethical approval, to ensure that the research study is conducted in compliance with the consent given by the ethics Committee and to the highest standards of rigour and integrity.

Please note, it is your responsibility to retain this letter for your records.

With the Committee's best wishes for the success of this project.

Yours sincerely,

Fernanda Silva

Fernanda Silva

Administrative Officer for Research Governance

University Research Ethics Committee (UREC)

Email: **researchethics@uel.ac.uk**

Appendix ii

Health Research Authority

Miss Rachel Allender
Trainee child and adolescent psychotherapist
[redacted]
rachel.allender@nhs.net

Email: hra.approval@nhs.net

22 February 2018

Dear Miss Allender

Letter of HRA Approval

Study title:	**What can be learnt from a pilot project offering brief therapeutic work to parents and infants in a Child and Adolescent Mental Health Service?**
IRAS project ID:	**228230**
REC reference:	**18/SW/0020**
Sponsor	**University of East London**

I am pleased to confirm that **HRA Approval** has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications noted in this letter.

Participation of NHS Organisations in England

The sponsor should now provide a copy of this letter to all participating NHS organisations in England.

Appendix B provides important information for sponsors and participating NHS organisations in England for arranging and confirming capacity and capability. **Please read *Appendix B* carefully**, in particular the following sections:

- *Participating NHS organisations in England* – this clarifies the types of participating organisations in the study and whether or not all organisations will be undertaking the same activities

- *Confirmation of capacity and capability* - this confirms whether or not each type of participating NHS organisation in England is expected to give formal confirmation of capacity and capability. Where formal confirmation is not expected, the section also provides details on the time limit given to participating organisations to opt out of the study, or request additional time, before their participation is assumed.
- *Allocation of responsibilities and rights are agreed and documented (4.1 of HRA assessment criteria)* - this provides detail on the form of agreement to be used in the study to confirm capacity and capability, where applicable.

Further information on funding, HR processes, and compliance with HRA criteria and standards is also provided.

It is critical that you involve both the research management function (e.g. R&D office) supporting each organisation and the local research team (where there is one) in setting up your study. Contact details and further information about working with the research management function for each organisation can be accessed from the HRA website.

Appendices

The HRA Approval letter contains the following appendices:

- A – List of documents reviewed during HRA assessment
- B – Summary of HRA assessment

After HRA Approval

The document *"After Ethical Review – guidance for sponsors and investigators"*, issued with your REC favourable opinion, gives detailed guidance on reporting expectations for studies, including:

- Registration of research
- Notifying amendments
- Notifying the end of the study

The HRA website also provides guidance on these topics, and is updated in the light of changes in reporting expectations or procedures.

In addition to the guidance in the above, please note the following:

- HRA Approval applies for the duration of your REC favourable opinion, unless otherwise notified in writing by the HRA.
- Substantial amendments should be submitted directly to the Research Ethics Committee, as detailed in the *After Ethical Review* document. Non-substantial amendments should be submitted for review by the HRA using the form provided on the HRA website, and emailed to hra.amendments@nhs.net.
- The HRA will categorise amendments (substantial and non-substantial) and issue confirmation of continued HRA Approval. Further details can be found on the HRA website.

Scope

HRA Approval provides an approval for research involving patients or staff in NHS organisations in England.

If your study involves NHS organisations in other countries in the UK, please contact the relevant national coordinating functions for support and advice. Further information can be found through IRAS.

If there are participating non-NHS organisations, local agreement should be obtained in accordance with the procedures of the local participating non-NHS organisation.

User Feedback

The Health Research Authority is continually striving to provide a high quality service to all applicants and sponsors. You are invited to give your view of the service you have received and the application procedure. If you wish to make your views known please use the feedback form available on the HRA website.

HRA Training

We are pleased to welcome researchers and research management staff at our training days – see details on the HRA website.

Your IRAS project ID is **228230**. Please quote this on all correspondence.

Yours sincerely

Gemma Oakes Assessor

Email: hra.approval@nhs.net

Copy to: *Ms Catherine Fieulleteau, University of East London [Sponsor Contact]*

researchethics@uel.ac.uk

[redacted]

Appendix iii

Are you concerned about your child who is under the age of five?

Would you be interested in hearing more about a current piece of research trialling an intervention for young children and their families?

Hello, my name is Rachel and I am a child and adolescent psychotherapist in the final year of my doctoral training. I am going to be conducting a pilot study, involving working with children under the age of five years old, who are experiencing some difficulties which are affecting their and their family's wellbeing and functioning. The project involves the child and their families being offered five therapy sessions, in order to help think about the difficulties they are experiencing.

You are being given this leaflet because you have either been referred directly to your local Child and Adolescent Mental Health Service (CAMHS) or your health visitor thinks this kind of support might be helpful for you and your child.

If you would be happy for me to make contact with you, to tell you more about the project, please let either your health visitor or your clinician know. Please be aware that by finding out more information you are not committing to taking part and are free to decline any further contact at any point.

Thank you.

Rachel Allender

Child Psychotherapist in Doctoral Training (University of East London),

Email: u1248998@uel.ac.uk

Appendix iv

University of East London
Docklands Campus, London E16 2RD

Information Sheet

Research Integrity

The University adheres to its responsibility to promote and support the highest standard of rigour and integrity in all aspects of research; observing the appropriate ethical, legal and professional frameworks.
The University is committed to preserving your dignity, rights, safety and wellbeing and as such it is a mandatory requirement of the University that formal ethical approval, from the appropriate Research Ethics Committee, is granted before research with human participants or human data commences.

The Principal Investigator/Director of Studies

Dr Margaret Lush
Tavistock and Portman Clinic
120 Belsize Lane
London NW3 5BA
mlush@tavi-port.nhs.uk

Student researcher

Rachel Allender
[redacted]
u1248998@uel.ac.uk

Consent to Participate in a Research Study

The purpose of this letter is to provide you with the information that you need to consider in deciding whether to participate in this study.

Project Title

What can be learnt from a pilot project offering brief therapeutic work to parents and infants in a Child and Adolescent Mental Health Service?

Project Description

<u>Who are the researchers?</u> This project is being conducted by Rachel Allender, a child psychotherapist in doctoral training. The sessions will be carried out by Rachel, who has a valid DBS Police check. This project has received formal approval from UREC.

What is the project? The project is a pilot, looking into brief work with young children and their families. The project involves families, with a child under the age of five who is experiencing some difficulties, being offered five sessions. The aim is to explore how this kind of work, involving parent(s) and their child(ren) is experienced by families and what effect it might have on the referring issue(s).

What is involved? If you take part, you will be asked to attend an initial meeting, which will last for 50 minutes, in which Rachel will ask you some questions and you have the opportunity to tell her more about your child's current difficulty. This meeting would ideally take place face-to-face, at (*the CAMHS Clinic*), however, if this is absolutely not possible, please let Rachel know, as it might be possible to have this meeting over the telephone.

Following this, you and your family will be offered five therapeutic sessions, all of which will be 50 minutes and will take place at the Clinic. In these sessions there will be time for us to talk about the current difficulties, think about how things have been in the past and your hopes for the future. I will provide some toys and paper and pens, and your child will be free to use the equipment in the room. These sessions will be a time for us to talk, think and play together with your child.

After these five sessions, you will be asked to attend an ending meeting in order to review the sessions. In this ending session, you will be asked to complete an 'Experience of Service' questionnaire, in order for Rachel to learn more about your experience of the work. As with the introductory meeting, it might be possible to have this conversation via the telephone, but it would be really helpful if you were able to attend in person. If possible, we would also like to arrange a follow-up meeting or conversation a few months after the project has ended. This conversation can take place over the telephone, or face-to-face.

Rachel will write notes after the sessions, and these will form the data for the project. No notes or recordings will be made during sessions.

This work is in addition to any current support you might be receiving, and will not impact on the involvement of other services, or future interventions. All of your appointments with Rachel will be separate to any existing appointments or interventions you might be receiving.

Why have you been chosen? You are being offered this work because you are worried about your young child, who is currently experiencing some difficulties. You have been identified because you have been referred directly to your local Child and Adolescent Mental Health clinic.

Are there any possible side effects? Due to the nature of the sessions, we might be talking about some difficult or upsetting things. In order to support you, you are able to contact Rachel or her clinical supervisor, should any difficulties arise.

What are the benefits to you? We hope that this work will be a helpful experience for you, and provide you with a space to talk and think about some of your current difficulties. This model of working has been used elsewhere and has been found to be very helpful for the families involved. We are, therefore, hoping that this pilot will give us a better idea about whether this kind of work could be useful within this service.

What happens to your information? Data might be published (in the form of a thesis or journal article), as part of this pilot project, or used for on-going work, including direct quotations from sessions. However, all personal details will be removed or anonymised, in order to ensure confidentiality.

If you take part, we will write to your GP in order to inform them.

What happens once the project is over? This project involves you being offered five sessions, plus an introductory and ending session. You will also be contacted after the project has finished for a follow-up meeting or conversation, in order for us to hear how things are for you and your family at that time.

Once the project and the writing up is complete, you can ask for an over-view of the findings. Please contact Rachel in order to request this information.

Should you require on-going support once this project is over, you will be directed to the relevant service, and a referral or request for further support will be made, where needed.

Confidentiality of the Data

Only Rachel will have access to your personal details (for example, address or telephone number) and this will only be used to make contact with you. In terms of any writing up of the project, we will ensure confidentiality by not using your names or identifiable information outside of the therapy sessions.

Any data relating to this project will be stored on password controlled computer systems and these will only be accessed by Rachel.

Your confidentiality will be maintained unless there is a disclosure which indicates the risk of serious harm to either you and your family, or someone else. In this case, Rachel will be required to share the relevant information to the relevant authority. Should this need arise, it will be discussed with you.

Personal data about you will be stored for up to twelve months after the project is complete, so we can contact you for follow up. Data regarding the findings of the pilot will be stored for up to ten years, however, this will not include any identifiable data about participants.

Any data generated in the course of the project will be retained in accordance with the University's Data Protection Policy.

The small sample size of this pilot might have an effect on the extent to which data can be completely anonymised. However, only Rachel will have access to the data, and all names and identifying details will be changed.

Location

The sessions will all take place at [redacted]. There is a free car park available on site and the Clinic also has good bus access to/from the surrounding areas.

Remuneration

There will be no remuneration for involvement within the project. Unfortunately, travel expenses will not be reimbursed.

Disclaimer

Your participation in this study is entirely voluntary, and you are free to withdraw at any time during the research. Should you choose to withdraw from the programme you may do so without disadvantage to yourself and without any obligation to give a reason. Please note that your data can be withdrawn up to the point of data analysis – after this point it may not be possible.

If you chose to withdraw once your sessions have begun, you will be offered the rest of the sessions.

Choosing not to participate will put you at no disadvantage for future treatment or intervention.

University Research Ethics Committee

If you have any concerns regarding the conduct of the research in which you are being asked to participate, please contact:

Catherine Fieulleteau, Research Integrity and Ethics Manager, Graduate School, EB 1.43
University of East London, Docklands Campus, London E16 2RD
(Telephone: 020 8223 6683, Email: researchethics@uel.ac.uk)

The management of this research is covered by UEL insurance, whilst the design and conduct of the project is covered by NHS insurance.

[redacted] Patient Advice and Liaison Service (PALS) can be contact via email:
[redacted]@nhs.net,
or by telephone: [redacted]

For general enquiries about the research please contact the Principal Investigator on the contact details at the top of this sheet.

Appendix v

UNIVERSITY OF EAST LONDON
Docklands Campus, London E16 2RD

Adult Consent Form

Project title: What can be learnt from a pilot project offering brief therapeutic work to parents and infants in a Child and Adolescent Mental Health Service?

Researcher: Rachel Allender

Please tick as appropriate:

	YES	NO
I have the read the information leaflet relating to the above programme of research in which I have been asked to participate and have been given a copy to keep. The nature and purposes of the research have been explained to me, and I have had the opportunity to discuss the details and ask questions about this information. I understand what is being proposed and the procedures in which I will be involved have been explained to me.		
I understand that my involvement in this study, and particular data from this research, will remain strictly confidential as far as possible. Only the researchers involved in the study will have access to the data. *(Please see below)*		
I understand that maintaining strict confidentiality is subject to the following limitations: The small sample size of the project might have implications for the confidentiality, in terms of data analysis. However, all data will be anonymised 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.		
I understand that anonymised notes will be written after sessions and these will form the data for the study		
I understand that the results of this research will be published, including direct anonymised quotes		
I understand that all data will be anonymized and no identifying details about me will be included within the write up		
It has been explained to me what will happen once the project has been completed, including that results will be published in the form of a thesis and journal articles		
I understand that I can contact the researcher after the project and writing up is complete, in order to ask for a summary of the findings		
I give permission for anonymised data, including quotes, from this research to be used in future studies by the researcher		

It has been explained to me what will happen once the programme has been completed.		
I understand that my participation in this study is entirely voluntary, and I am free to withdraw at any time during the research without disadvantage to myself and without being obliged to give any reason. I understand that my data can be withdrawn up to the point of data analysis and that after this point it may not be possible.		
I understand that one copy of this consent form will be stored within the clinic in patient medical records, one copy will be stored by the researcher and one copy will be given to me to take away		
I hereby freely and fully consent to participate in the study which has been fully explained to me and for the information obtained to be used in relevant research publications.		

Participant's Name (BLOCK CAPITALS)
…………………………………………………………………….

Participant's Signature
………………………………………………………………………………………..

Investigator's Name (BLOCK CAPITALS)
…………………………………………………………………..

Investigator's Signature
………………………………………………………………………………………

Date:
………………………….

Appendix vi

UNIVERSITY OF EAST LONDON
Docklands Campus, London E16 2RD

Child Consent Form

Project title: What can be learnt from a pilot project offering brief therapeutic work to parents and infants in a Child and Adolescent Mental Health Service?

Researcher: Rachel Allender

Please tick as appropriate:

	YES	NO
I have the read the information leaflet relating to the above programme of research in which my child and I have been asked to participate and have been given a copy to keep. The nature and purposes of the research have been explained to me, and I have had the opportunity to discuss the details and ask questions about this information. I understand what is being proposed and the procedures in which I will be involved have been explained to me.		
I understand that my child/children's involvement in this study, and particular data from this research, will remain strictly confidential, as far as possible, and only the researcher involved in this study will have access to the data. *(Please see below)*		
I understand that maintaining strict confidentiality is subject to the following limitations: The small sample size of the project might have implications for the confidentiality, in terms of data analysis. However, all data will be anonymised 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.		
I understand that anonymised notes will be written after sessions and these will form the data for the study		
I understand that the results of this research will be published, including direct anonymised quotes		
I understand that all data will be anonymized and no identifying details about me will be included within the write up		
I understand that my child's GP will be informed of the involvement in this research, and will be updated on any changes during the project		
It has been explained to me what will happen once the project has been completed, including that results will be published in the form of a thesis and journal articles		

I understand that I can contact the researcher after the project and writing up is complete, in order to ask for a summary of the findings		
I give permission for anonymised data, including quotes, from this research to be used in future studies by the researcher		
It has been explained to me what will happen once the programme has been completed.		
I understand that my child's in this study is entirely voluntary, and we are free to withdraw at any time during the research without disadvantage and without being obliged to give any reason. I understand that data can be withdrawn up to the point of data analysis and that after this point it may not be possible.		
I understand that due to my child/children's age, I am being asked to give full consent on their behalf		
I understand that one copy of this consent form will be stored within the clinic in patient medical records, one copy will be stored by the researcher and one copy will be given to me to take away		
I hereby freely and fully consent to participate in the study which has been fully explained to me and for the information obtained to be used in relevant research publications.		

Child's Name (BLOCK CAPITALS)
…………………………………………………………………….

Parent's Name (BLOCK CAPITALS)

…………………………………………………………………….

Parent's Signature (On behalf of their child)

……………………………………………………………………………………..

Investigator's Name (BLOCK CAPITALS)

…………………………………………………………………..

Investigator's Signature

………………………………………………………………………………………

Date:
…………………………..

Appendix vii

Dear GP,

Re. Patients name – DOB - NHS number

I am writing to inform you that the above named patient has given consent (or consent has been given on their behalf by their parents) to take part in a piece of research which I am conducting, as part of my doctorate training in child and adolescent psychotherapy.

The project is a pilot, looking into brief work with young children and their families. The project involves families, with a child under the age of five who is experiencing some difficulties, being offered five sessions. It is a model which has been used extensively in other clinics, and has been found to be very effective, however it is new to this current service.

The aim is to explore how this kind of work, involving parent(s) and their child(ren) is experienced by families and what effect it might have on the referring issue(s). At the end of the intervention, the families will be returned to the care of their referrer, or if on-going support is needed, I will direct families to the relevant service, and make a referral, where needed.

I am conducting this research in order to learn more about parent-child psychotherapy and to see how this treatment method is received by the families involved and by the clinic. The patient has been identified by either referral into our service directly, or by their health visitor, due to them current experiencing one or more difficulties, which are having an impact on their functioning and wellbeing.

Should you require any further information about my research, or wish to discuss this letter in more detail, please do not hesitate to make contact.

If any changes to the treatment plan arise, I will inform you accordingly.

Yours faithfully,

Rachel Allender

Child Psychotherapist in Doctoral Training

Appendix viii

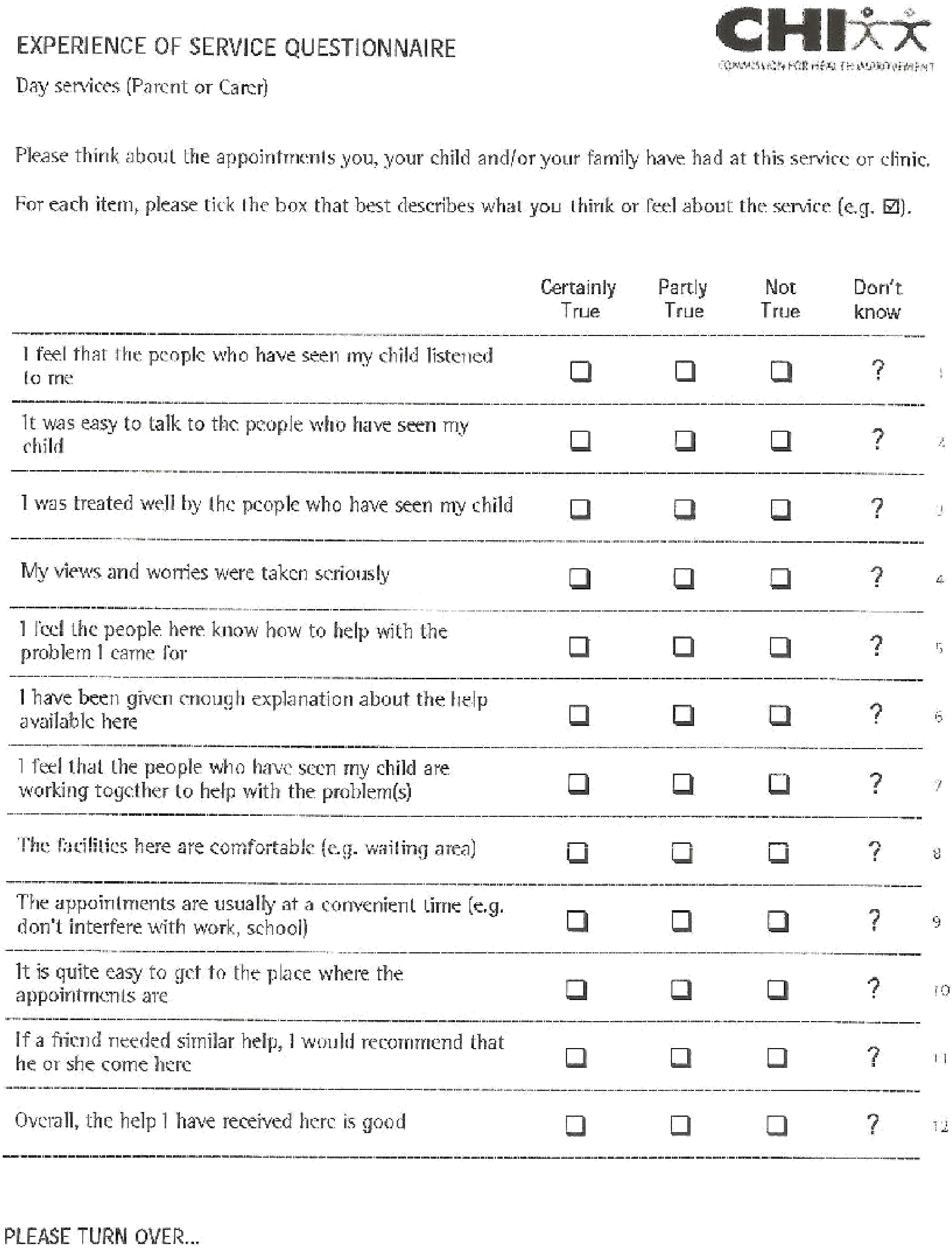
Semi-structured interview schedule

Project title: What can be learnt from a pilot project offering brief therapeutic work to parents and infants in a Child and Adolescent Mental Health Service?

Due to this pilot involving psychoanalytically informed working, the aim of the interview is to open up areas of conversation and learn more about the family, from their perspective, rather than asking them a set of specific questions. Therefore, the interview schedule below provides prompts for the kinds of areas I would be interested in learning about, whilst also giving an opportunity for the families to explore the areas salient to them, and for me to learn about the dynamic in the room.

1) What brings you here today? What has been worrying you?
2) Do you have any ideas about what might have caused this difficulty/difficulties? How have things been at home generally, what has been going on?
3) How have you all been getting along with each other, in these difficult circumstances?
4) Have there always been difficulties? How have things been throughout (your child’s) life? Prompts could include – how were the pregnancy and the birth, and can you describe the early relationships?
5) As part of this intervention, we will start by setting some goals for the treatment. What are some of the problems you would like help with, or goals you hope to achieve (if not already obvious from previous discussion)? Please rate each of these from between 0-10. We will review these goals at the end of the treatment, and at follow up, if possible.

Appendix ix



CHI
COMMISSION FOR HEALTH IMPROVEMENT

EXPERIENCE OF SERVICE QUESTIONNAIRE

Day services (Parent or Carer)

Please think about the appointments you, your child and/or your family have had at this service or clinic.

For each item, please tick the box that best describes what you think or feel about the service (e.g. ☑).

	Certainly True	Partly True	Not True	Don't know	
I feel that the people who have seen my child listened to me	☐	☐	☐	?	1
It was easy to talk to the people who have seen my child	☐	☐	☐	?	2
I was treated well by the people who have seen my child	☐	☐	☐	?	3
My views and worries were taken seriously	☐	☐	☐	?	4
I feel the people here know how to help with the problem I came for	☐	☐	☐	?	5
I have been given enough explanation about the help available here	☐	☐	☐	?	6
I feel that the people who have seen my child are working together to help with the problem(s)	☐	☐	☐	?	7
The facilities here are comfortable (e.g. waiting area)	☐	☐	☐	?	8
The appointments are usually at a convenient time (e.g. don't interfere with work, school)	☐	☐	☐	?	9
It is quite easy to get to the place where the appointments are	☐	☐	☐	?	10
If a friend needed similar help, I would recommend that he or she come here	☐	☐	☐	?	11
Overall, the help I have received here is good	☐	☐	☐	?	12

PLEASE TURN OVER...

What was really good about your care? 13

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____

____

____

____

Was there anything you didn't like or anything that needs improving? 14

____

____

____

____

____

Is there anything else you want to tell us about the service you received? 15

____

____

____

____

____

Child's age: ____________ Child's gender: Female ☐ Male ☐

Child's ethnicity: White ☐ Black/Black British ☐ Asian/Asian British ☐

Mixed ☐ Other ☐

Is your child registered disabled (e.g. hearing-impaired)? No ☐ Yes ☐

If you don't want to take part, please tick this box ☐ and return the blank questionnaire in the envelope provided.

THANK YOU FOR YOUR HELP

Now place this form in the envelope provided and put it in the box marked CHI in the reception

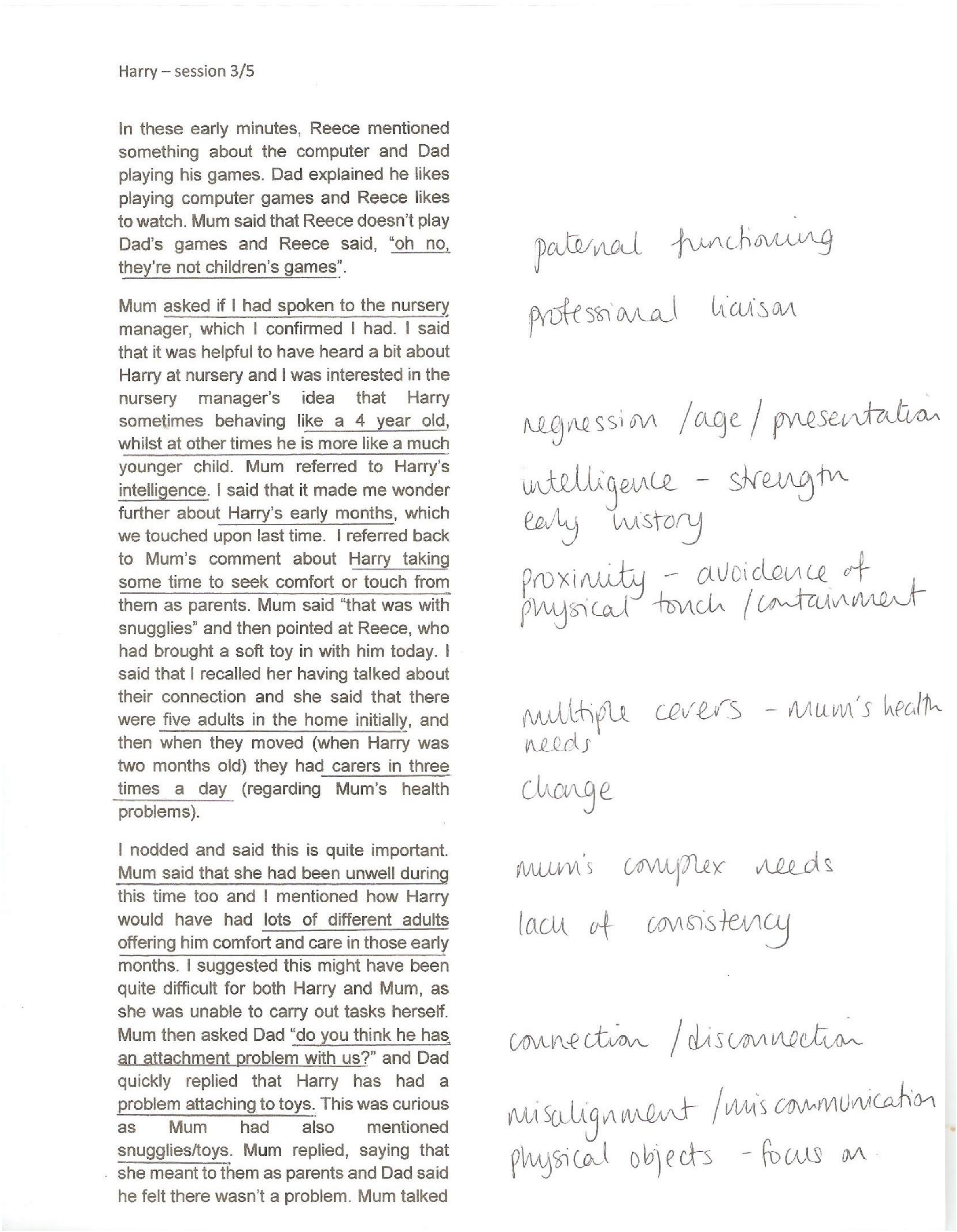
For administration purposes

Trust: ____________

Service: ____________ Code: ______

Tier: ____________ DB No: ______

Appendix x



Harry – session 3/5

In these early minutes, Reece mentioned something about the computer and Dad playing his games. Dad explained he likes playing computer games and Reece likes to watch. Mum said that Reece doesn't play Dad's games and Reece said, "oh no, they're not children's games".

Mum asked if I had spoken to the nursery manager, which I confirmed I had. I said that it was helpful to have heard a bit about Harry at nursery and I was interested in the nursery manager's idea that Harry sometimes behaving like a 4 year old, whilst at other times he is more like a much younger child. Mum referred to Harry's intelligence. I said that it made me wonder further about Harry's early months, which we touched upon last time. I referred back to Mum's comment about Harry taking some time to seek comfort or touch from them as parents. Mum said "that was with snugglies" and then pointed at Reece, who had brought a soft toy in with him today. I said that I recalled her having talked about their connection and she said that there were five adults in the home initially, and then when they moved (when Harry was two months old) they had carers in three times a day (regarding Mum's health problems).

I nodded and said this is quite important. Mum said that she had been unwell during this time too and I mentioned how Harry would have had lots of different adults offering him comfort and care in those early months. I suggested this might have been quite difficult for both Harry and Mum, as she was unable to carry out tasks herself. Mum then asked Dad "do you think he has an attachment problem with us?" and Dad quickly replied that Harry has had a problem attaching to toys. This was curious as Mum had also mentioned snugglies/toys. Mum replied, saying that she meant to them as parents and Dad said he felt there wasn't a problem. Mum talked

paternal functioning

professional liaison

regression / age / presentation

intelligence - strength
early history

proximity - avoidance of
physical touch / containment

multiple carers - mum's health
needs

change

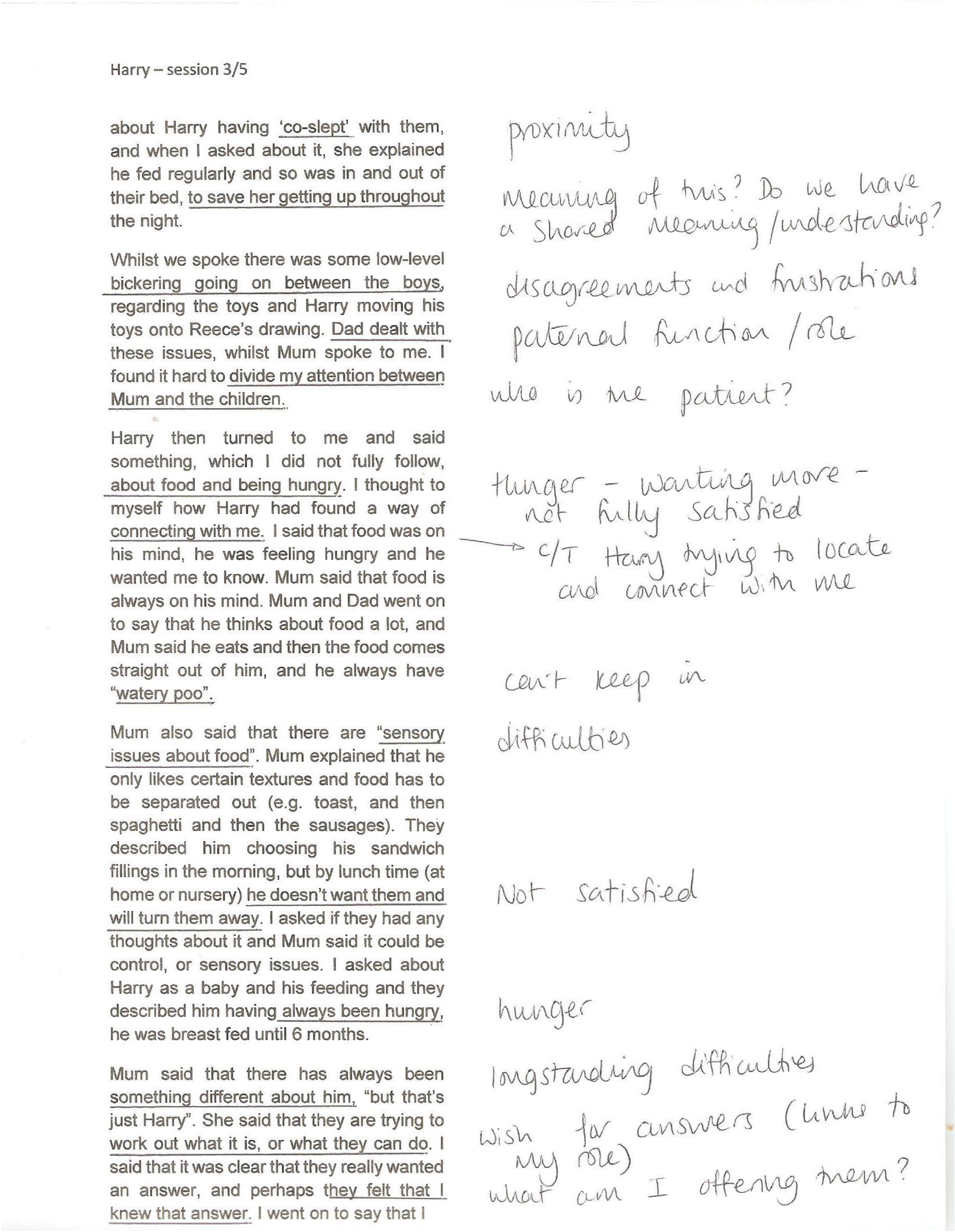
mum's complex needs

lack of consistency

connection / disconnection

misalignment / miscommunication

physical objects - focus on



Harry – session 3/5

about Harry having 'co-slept' with them, and when I asked about it, she explained he fed regularly and so was in and out of their bed, to save her getting up throughout the night.

Whilst we spoke there was some low-level bickering going on between the boys, regarding the toys and Harry moving his toys onto Reece's drawing. Dad dealt with these issues, whilst Mum spoke to me. I found it hard to divide my attention between Mum and the children.

Harry then turned to me and said something, which I did not fully follow, about food and being hungry. I thought to myself how Harry had found a way of connecting with me. I said that food was on his mind, he was feeling hungry and he wanted me to know. Mum said that food is always on his mind. Mum and Dad went on to say that he thinks about food a lot, and Mum said he eats and then the food comes straight out of him, and he always have "watery poo".

Mum also said that there are "sensory issues about food". Mum explained that he only likes certain textures and food has to be separated out (e.g. toast, and then spaghetti and then the sausages). They described him choosing his sandwich fillings in the morning, but by lunch time (at home or nursery) he doesn't want them and will turn them away. I asked if they had any thoughts about it and Mum said it could be control, or sensory issues. I asked about Harry as a baby and his feeding and they described him having always been hungry, he was breast fed until 6 months.

Mum said that there has always been something different about him, "but that's just Harry". She said that they are trying to work out what it is, or what they can do. I said that it was clear that they really wanted an answer, and perhaps they felt that I knew that answer. I went on to say that I

proximity

meaning of this? Do we have a shared meaning/understanding?

disagreements and frustrations

paternal function / role

who is the patient?

Hunger – wanting more – not fully satisfied

→ C/T Harry trying to locate and connect with me

can't keep in

difficulties

Not satisfied

hunger

longstanding difficulties

wish for answers (links to my role)

what am I offering them?

wondered if this might link to a worry about something being missed or over looked. I reflected that in their own lives they might have had experiences of having had to wait, or something being missed, and this might impact on how they are approaching Harry's needs now. Mum was silent, staring and me and then said "I guess so", and reflected that she and Dad have had issues in their lives. Mum spelt out the word 'rape' and referred to having had to flee after this incident. I nodded, aware of how evident Mum's sadness and pain in relation to this event were. She then added that they just want the best for the boys.

I nodded and said that this was clear and we are working together to think about the current difficulties and what might help. I confirmed that my job isn't to offer a diagnosis but rather to think with them about what's happening at the moment. Mum said, "I know" (in relation to my role). There was some conversation with the boys then about their play, with Reece wanting to show me his drawing and Harry looking for certain toys in the box. Harry had a small digger toy which he began to push into the pen pot, and I commented on this, the digger digging deep into the pot, searching for something. Eventually the pot fell over and both parents said quickly that he needed to pick up the pens. These quick requests for Harry to tidy up allowed little space for me to comment further on what had happened.

Mum then, rather abruptly (in a similar way to her requests for the pens to be tidied) asked if I had thought of any technique for them to try. I said I thought it would be helpful for us to continue to think about what they are seeing now in Harry, but also their early memories and experiences of being with Harry. Mum looked somewhat frustrated and I felt that she was waiting only for me to give her a list of strategies to try. I referred to Mum's previously

oversight – what is seen or noticed?

parental experiences

trauma /escape

focus on the children

my role

digger = investigation (linking to my role)
wish to find something
avoidance of mess
what can I comment on, silence, shutting down

strategies /techniques
→ can we think?
focus on early experiences
disappointment in me

comments that there has always been something different, such as the head-banging. I paused and waited to see if Mum or Dad had any thoughts. Mum said that he had head-banged since he was first born, or rocked back at forth. I asked if he does this if they are present and Mum quickly said yes. I reflected on this, something physical which Harry, for some reason, has linked with relaxing or sleep. I referred back to earlier in the session, when Harry had been lying on dad's lap, whilst Dad patted him. I said that the image felt reminiscent of a baby, being rocked or patted. They said that he enjoys compression and touch. I said that perhaps that could be something to think about in terms of the head-banging, is there another, safer, way in which Harry could feel touch and physicality, such as Dad stroking his back or being close until he falls asleep. Mum said they had tried staying with him until he falls asleep and with a somewhat dismissive laugh she added, "we've tried everything".

physical expression

self-soothing

physicality

comfort

infantile needs

paternal role

dispair

I said that I understood they had tried a lot and really want to find some other way of doing things, but I was just reflecting on what I had observed today – how soothed Harry is by touch. Mum said, in a tone which appeared a little disgruntled, "well we can try it again". As I continued talking, she took something from her bag and I soon realised it was a large stack of post-it notes upon which she was writing down exactly what I had said – as though I had given her a clear instruction which needed to be recorded.

comfort

professional advice - recording of
↳ adhesive connection

Whilst Mum was writing down, she suddenly pointed at Harry, looking at Dad and said, "he's smashed his head now" and she then told Dad to tend to Harry . I look round to see Harry with his mouth wide open, silently crying. This was curious, and felt quite disturbing, because whilst the pain was evident on Harry's face, he did not make any noise to communicate this, and

injury / pain

silence - no noise
↳ what is known or expressed?

interestingly, until Mum commented, I had not noticed that Harry had hurt himself. Dad called him over and Reece quickly stood and put an arm around Harry as he walked. Mum continued to trying to talk to me, but I had my attention on Harry, commenting on a bump to his head, and how he needed a big cuddle from daddy. Harry snuggled into dad, who kissed his head. He then asked Reece for a toy, which Reece retrieved for him. It was noticeable that Mum quickly returned to the conversation and did not directly try to comfort Harry herself. I remained quiet for a few moments, observing, and then commented on Reece's response – how he had really wanted to comfort his little brother, with a cuddle and fetching a toy. Reece smiled, looking proud and pleased that this had been noticed. I thought to myself about what is noticed, how do these boys get noticed, or what goes un-noticed?

Mum said that Reece has always been like that, asking if everyone is okay and checking on them. I said that might link to his experiences of Mum and Dad's health, whereby they have been unwell at times. Mum nodded and said that he always checks if she's okay. Reece nodded and said he did. I asked a bit more about Mum's health and she said that it is very changeable, sometimes she is able to do everything with the boys, whilst other times she can't do anything and is in a wheelchair. She again added that it has *always been like this*. I agreed, commenting on frustrating this must be for her. I then encouraged her to think more with me about this, from the boys' perspective - how one day they could have a very active mummy, and other days they might need to care for Mum. Mum said that Reece is a "young carer", although not officially because of his age – she then muttered something about it not being recognised because she's under adult social care. I did not quite follow what she

parentified

physical reassurance

contrast between mum and dad's responses
↳ C/T painful to observe

being seen

worry / anxiety
physical & mental health

inconsistent

nothing changes

active vs. passive roles

Harry – session 3/5

meant, but she sounded cross about this, and added "that's another story". I gave an example of bath-time, and asked whether her illness meant that sometimes she would do such tasks and other days she would be unable. Mum interjected quickly and said she's never done bath-time because "the boys need consistency", so bathing is always carried out by her carer. I felt unsure of what to say, as though that conversation had been shut down. She added, "and we don't have a bath anyway, we have a shower", she then laughed a lot.

frustration
lack of clarity

routine
role of carer
restrictions

I nodded and said that it might still be important to think about, because there must be times when she is very engaged with the children, but other times when she cannot be, and the boys might worry about her during her periods of ill-health Mum said she does "snuggle time" with them every night and that's consistent.

a space to think

physical comfort

Mum began talking about Harry's toileting and how Harry has always had to take himself to the toilet, because by the time she's got herself upstairs in the stair lift, it would be too late. I acknowledged how hard that must be for them, and the adjustments they must all have to make. Mum mentioned Harry 'smearing' and we spoke about this for a few minutes. I recalled her having said that he smeared every time he toiletting, so I asked about this again and Mum said that because he has an upset stomach all the time anyway, "it just goes everywhere". She added that he also sticks his hands in it. When I asked again about how often this happens, she asked Dad and he said it was not so often now, and Mum nodded and said it was just sometimes.

evacuation
lacking parental support

mess

illness – physical expression
lack of containment

Harry had come closer to Mum during this conversation and she asked him directly why he plays with his poo. He thought for a moment and says it gets stuck, and he can't get it out. Reece began to laugh and Mum told Reece to be quiet. I repeated what

Proximity

stuck

Harry – session 3/5

Harry had said, referring to something being stuck and painful, and Harry needing some help to get it out. I asked Mum and Dad if that was something they had observed. Mum said that the poo is so watery, there was no way it could get stuck. I enquired into whether they had been to a GP about this issue and Mum said no. I suggested it might be worth looking into, if it is a longstanding problem. Mum referred to nursery sending him home at times because they think he has a diarrhoea bug, but in fact it is just normal. Writing this up I became aware of the contradictions between hard and soft – something so stuck it can't be freed, in contrast to something so un-contained.

We returned to talking about the boys' routines and Mum commented on their high levels of energy, making reference to how they had been during the session (which did not seem particularly out of the ordinary to me). I asked about physical activity for them and Mum said they have free run of the garden and they go swimming and run around etc. I asked what she notices when they don't have so much activity and she said that their behaviour gets worse. She referred again to them playing in the garden, and I asked whether that was alone or with Mum and Dad, Mum said generally on their own, but added that the garden is completely child-proof and safe. I had a sense of the children being left to exercise/entertain themselves.

I asked more generally about the things they like to do together, and Reece said quickly "me and him (dad) love the computer", and Mum said she does not like the computer, but both boys have iPads. I asked what she and Harry like and she said he likes playing, and she likes arts and crafts. I tried to explore this further, in terms of what time, if any, they spend playing or doing an activity together but Mum seemed

trying to listen to Harry's voice

differences in opinion/views

are Harry's needs responded to?

illness

C/T

physicality - expression

energy - need for physicality

distance from parents

connection

creativity

to move away from this, in a somewhat protective way. She said something about things needing to be clean "because of my OCD" and explained that she likes to have things "clean" but not necessarily tidy. She added that they can do what they like with their toys but she likes the house to be clean and "Dad is my cleaner". Dad smiled.

disconnection

maternal mental health vs. mess

Dad's role

Shortly after this, Harry picked up a digger and pretended to throw the contents at me, he giggled and said it was mud. I said "oh dear, I'm having mud thrown right at me", he laughed and continued, throwing more and more. I said that I would be in quite a mess after all this mud. I commented on how Mum and I had just been talking about toileting and mess at home, and now Harry was making me into a big muddy messy therapist. He seemed to get more and more excited by the idea, pretending to fill up a pot. Eventually, in his excitement, the pot got thrown at me too, and then the room fell silent, before Mum shouted, "that's enough!".

connection with me

mess - attack

Harry's connection / expression

lack of containment ↳ escalation

anger

I said that all of a sudden the pot had got thrown too, and all the messy mud had gone everywhere. Harry looked somewhat frightened, and I said that we needed to be careful in the room, to make sure we were all safe. Mum said, "what do you say?" and Harry said "sorry" before returning to his play.

safety

It was very nearly time to finish, so I said that in a few minutes the boys would need to finish their playing and we would tidy up. Immediately, Reece packed all of the pens away. Whilst doing so, he knocked a pot over and said quickly, "I will tidy that up".

fear of parental response

In the final minutes, Harry picked up his pictures and I said that he could leave them with me and I'll bring them back next time. He nodded and I asked if he wanted to show me his pictures, which he said he did, bringing them over. He showed me an

connection - focus back to Harry

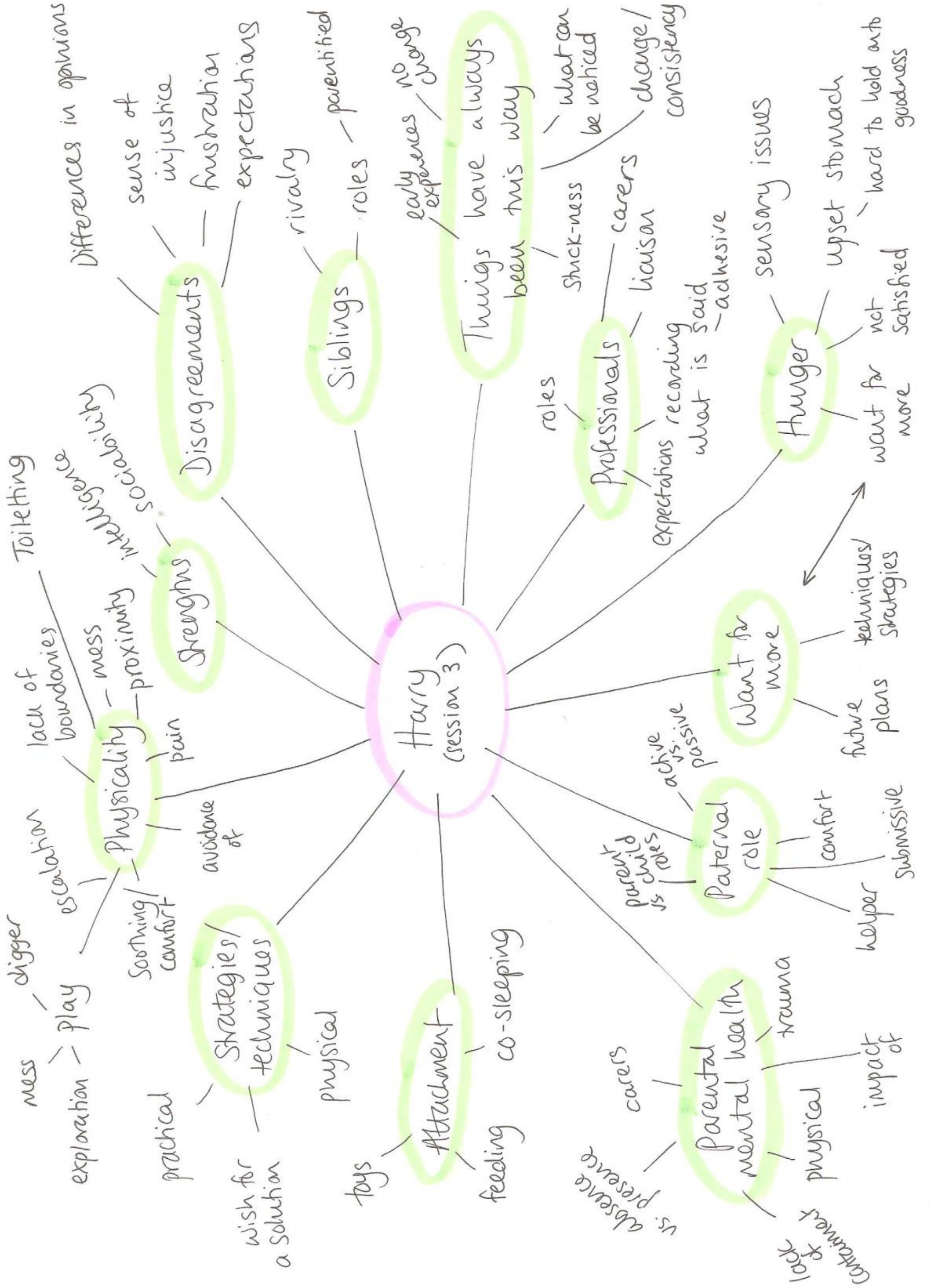
outline of his hand, and then a picture of some mud (for the digger toy), with a spider on it. As he talked, Reece began to add things in too and Mum and Dad told him to be quiet, and that this time 'wasn't about him'.

C/T digger – exploration and/or mess
spider – frightening, hard to get hold of
who is the patient?

In the final seconds, Harry tried to add another line to his drawing and we then left the room together. I asked whether Reece would be coming next time and Mum and Dad both said, "hopefully not". I addressed Reece, saying that I would perhaps see him next time, and then said to Harry that I would see him next week. The conversation regarding getting water from the water machine began again. As we reached the doors, I said goodbye and they left the clinic.

aggression

Appendix xi


Harry (session 3)
Disagreements
Differences in opinions
sense of injustice
frustration
expectations
Siblings
rivalry
roles
parentified
Things have always been this way
early experiences
no change
what can be noticed
change/consistency
stuck-ness
Professionals
carers
liaison
recording what is said
adhesive
roles
expectations
Hunger
sensory issues
upset stomach
hard to hold onto goodness
not satisfied
want for more
Want for more
techniques/strategies
future plans
Paternal role
active vs passive
comfort
submissive
helper
parent vs child roles
Parental mental health
trauma
impact of
physical
lack of containment
absence vs presence
carers
Attachment
co-sleeping
feeding
toys
Strategies/techniques
physical
wish for a solution
practical
Physicality
Toiletting
lack of boundaries
mess
proximity
pain
avoidance of
soothing/comfort
escalation
play
digger
mess
exploration
Strengths
intelligence
sociability

Appendix xii

Session 1

- Parental needs
- Paternal role
- Connection with me
- Routine
- Siblings
- Things have always been this way
- Role of professionals
- Physicality
- Sociability
- Hearing the child's voice
- Diagnosis
- Hopelessness

Session 3

- Disagreements/Hopelessness/frustration
- Siblings
- Things have always been this way
- Role of professionals
- Hunger
- Carers (role of adults)
- Intelligence
- Paternal role
- Parental needs (mental health)
- Attachment
- Techniques/strategies
- Regression
- Physicality
- Hearing the child's voice

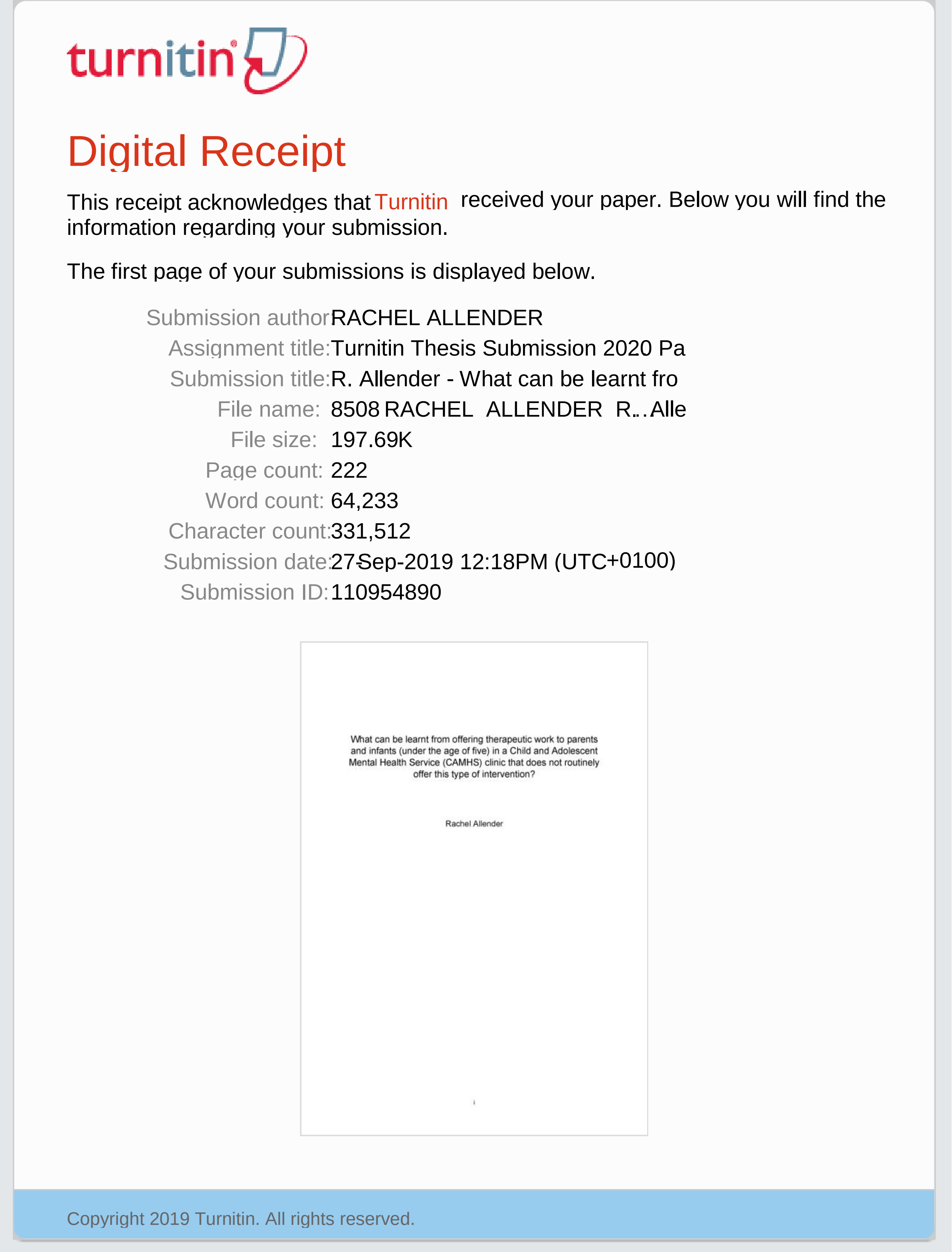
Session 5

- Absence of dad/Paternal role
- My role
- Last session
- Mother's difficulties
- Change
- Irritability
- Physicality
- Diagnosis
- Where next?
- Siblings

🩷 = who is the patient
🟪 = distance / proximity
🟦 = wish for more
🟥 = role
🟨 = change / transitions
🟩 = physicality

Family 2 - Harry

Appendix xiii



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What can be learnt from offering therapeutic work to parents and infants (under the age of five) in a Child and Adolescent Mental Health Service (CAMHS) clinic that does not routinely offer this type of intervention?

Rachel Allender

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