How do Child Psychotherapists understand their role when working with children under 5 years old, their families and the professionals around them?

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Abstract

Objectives A small scale qualitative study to explore (i) child psychotherapists' understanding of their role when working with children under 5's and their families, within their teams and with the professional networks tasked with supporting children under 5 and (ii) the notion of a child psychotherapists' 'role' within the context in which they are working.

Method Seven qualified and ACP registered child psychotherapists who were currently and frequently engaged in work with children under 5 years old took part in semi structured interviews. Interviews were transcribed verbatim and were analysed using Thematic Analysis.

Results An examination of the notion of child psychotherapists' role when working with children under 5's, their families and the networks around them produced five key themes: 'work', 'task', 'position', 'duty' and 'lived experience'.

Conclusions The findings of the research suggested that child psychotherapists working with under 5's view their role as nuanced and multifaceted. The research also indicated that the psychoanalytic lens used within clinical work extended outside of clinical work and was employed by clinicians in interactions within their teams and in the wider network. Additionally, cross over was observed between the psychoanalytic notion of the role of the mother in mother-infant dyads, the role that the clinician took up within their clinical work and the role that clinicians played when working with individuals or networks of professionals supporting children under 5. This suggested that the management and containment of and capacity to think about anxiety, particularly that of an infantile quality, took place in all aspects of the role of a child psychotherapist. Too, the findings draw attention to the particularities of the skill set and knowledge base held by child psychotherapists, enabling them to play a unique role, not only in direct clinical work, but within their teams and within the network around them too.

Key words

Infants; parent and infant psychotherapy; role; child psychotherapy; under 5's professionals.

1.Introduction

1.1 Conceptual and clinical rationale

With an ever-growing societal and professional recognition[1] of the impact that a child's first years of life have on later development and subsequently the importance of early intervention, recent decades have seen a call for services involved in the care of children under 5 years old to be able to effectively deliver early interventions and to support the psychological needs of babies, children, and their parents in first few years of life.

Observing, understanding, and working therapeutically with young children is a central aspect of trainings for Child and Adolescent Psychoanalytic Psychotherapists across the UK. Child psychotherapists[2] have played a well-documented part in establishing, contributing to, and supporting under 5's services and have contributed to the thinking and ethos of the teams they work within. However, despite their historic presence in such services, Child Psychotherapy is a small discipline[3] and other professionals in the wider under 5 network are likely to seldom encounter a child psychotherapist within their day to day professional activity. The scarcity of child psychotherapists along with their particular way of understanding young children may, at times, lead to their contributions to teams, services and networks being well valued. However, the rarity of child psychotherapists in this area of work might also lead to their role, contributions to the team and way of understanding infants, young children and parents becoming

[1] Evidence of societal and professional recognition is indicated by and documented within 'The First 1001 days movement', a group of UK based organisations and professionals working together to campaign for the importance of the emotional wellbeing of babies. 'The first 1001 days Movement' works collaboratively with the 'Conception to age two all-party parliamentary group', an all-party UK parliamentary group tasked with understanding the needs and challenges faced by babies and young children and advocating for policy change.

[2] Henceforth, I will use the term 'Child psychotherapist/s' to refer to those holding a clinician qualification in Child and Adolescent Psychoanalytic Psychotherapy, recognised by the association of child psychotherapists (ACP).

[3] In the UK Child Psychotherapy is a relatively small profession, with (as of January 2021) only 1001 members registered with the Association of Child Psychotherapist, inclusive of trainee members and those registered as 'not working' or living overseas. Of these, only a small proportion regularly engage with working with children under 5 and their families.

shrouded in mystery, or else misunderstood, met with hostility or somewhat overlooked.

During my professional training as a child and adolescent psychotherapist, I held part of my training post in a service which exclusively aimed to support the needs of children under 4 years old and their families. This emersion into the world of the under 5 and my own experiences in finding my way as a child psychotherapist in training within this specialism contributed hugely to my interested in this area. Throughout my 4-year training, I observed and experienced the complexities of not only working directly with young children and their families but of working as a member of the network of professionals also involved in the care and support of children under 5 years old. This research was borne out of these experiences and my own curiosity about how qualified child psychotherapists working within this specialism viewed and understood their place and position in their work.

Through this small-scale research study, I hope firstly to shed further light on child psychotherapists' current approach to working to support children under five by seeking to explore and capture a sense of their 'way of seeing', approach to working and their perception of their role. The word 'role' is of importance within this research but is one that defies easy definition. Cambridge dictionary defines it as "the position or purpose that someone… has in a situation, organization, society, or relationship", whilst Merrier Webster offers a broader definition of "(i) a character assigned or assumed, (ii) a socially expected behaviour pattern usually determined by an individual's status… (iii) a function or part performed especially in a particular operation or process"[4]. Intuited from these two definitions together is that the subject of one's role may be quite an elusive matter. The definitions suggest that roles could be considered as complex moving and shifting positions that are both context dependant as well as highly interpersonal.

The ever-increasing recognition of the need for the provision of early intervention in child mental health matters carries with it the inevitable questions of what these

[4] Definitions of the word 'role' were sourced from Cambridge dictionary online; https://dictionary.cambridge.org/ and Merriam - Webster dictionary online; https://www.merriam-webster.com/dictionary.

interventions might look like and how to monitor their success. Financial demands combined with increasing pressure to 'capture outcomes' within services can lead to the prioritisation of cost effective, evidenced based and manualised approaches over more nuanced and attuned approaches to providing intervention. In turn this can lead to the risk of one's role being reduced to one's effectiveness at monitoring client outcomes and a stripping away the other more nuanced and less easily 'captured' functions or dimensions of a professional's role. Therefore, a further motivating factor behind this study is the hope to unpick and expand upon the notion of the 'role' or function that child psychotherapists might play, not just with their therapeutic work with patients but within the wider structures that they work within, and through doing so to expand the discourse around the notion of what might constitute as activity within one's role.

1.2 *Research Aims*

This research aims to shed light on the current role and working practice of child psychotherapists engaged in supporting children under 5, as understood by child psychotherapists, and through doing so, to examine the contributions, approach, and challenges faced by child psychotherapists in relation to under 5 working. This research presupposes that the child psychotherapist's role may extend beyond that of only working directly with children and families but that they may play particular roles within their teams and within the networks around them.

Thus, the central research question is:

How do child psychotherapists understand their role when working with children under 5 years old, their families, within their teams and within the wider network of professionals[5] around them.

[5] Typically, but not exclusively consisting of nursery staff, midwives, health visitors, GPs, social workers, family support workers and those working in children's centres and perinatal mental health services.

Broader aims will be to:

- Gain further insight into the current working practices of and challenges faced by child psychotherapists engaged in under 5 work.

- Explore the notion of a child psychotherapists' 'role' within the context of working with under 5's, their families, their teams and the surrounding under 5's professional network.

2 Literature Review

2.1 Introduction

As it stands, there is very little literature which aims to, as its primary focus, address the role of a child psychotherapist when working with children under 5. Rather, insight or ideas about 'role' can be found in piecemeal forms, scattered throughout an almost endless bank of psychoanalytic literature relating to this specialism. To contextualise my research, within this review I have set out to examine literature that explores, defines, or provides insight into the 'role' of a child psychotherapist when working with young children, families and with professionals from related disciplines. I view that a child psychotherapist's practice and approach to working and thus their 'role' is heavily shaped by their subscription to shared theoretical principles, knowledge of related theoretical frameworks and experiential learning within their 6-year training. As such, this review will begin with an examination of how child psychotherapists think about babies and young children, starting with some core theoretical contributions of influential early child psychotherapists, followed by contemporary theoretical contributions. The review will then address some further developments in thinking and practice which relate to infants and children under 5 years old, with a particular focus on the development of the 'infant observation' module, introduced by Ester Bick as a foundational aspect of the training of child psychotherapists, as well as the development of a psychoanalytically informed model of brief intervention with young children and their families, developed within the Tavistock and Portman Foundation Trust's former 'Under 5's service' and documented by Bradley and Emanuel (2008).

The review will then examine additional psychoanalytically informed ways of working with children under 5, exploring alternative models of working and adapted or applied methods of working with families and young children. The review will conclude with an exploration of psychoanalytic literature that considers the role and function of child psychotherapists within their teams and within related services, predominantly addressing the place and practice of psychoanalytic supervision and consultation when working with a broad range of professional services involved in the care of children.

2.2 Methodology of review

The aim within this review is to gather literature which, taken together, provide a comprehensive overview and insight into the psychoanalytic way of thinking about and working with infants, young children, their families, and related professionals in order to provide context for the central question that this research seeks to address. This was a complex task due to the sheer volume of psychoanalytic writing on the subject.

As I aim to provide a representation of a typical child psychotherapist's view on infancy, I began with theory and learning that is foundational in the training of all ACP registered child psychotherapists which includes the theoretical underpinning of Melanie Klein and/or Donald Winnicott[6] coupled with the experiential learning gained through conducting an 'Infant observation'. Following this, I have primarily relied on my own discretion when choosing what to include or exclude from this review. I have sought to include theorists widely known to have made important contributions to the understanding of infancy, such as Bion and Bick and have included those known to have specialised in working with infants and young children, such as UK based child psychotherapists and authors Margaret Rustin, Louise Emanuel, and Dilys Daws amongst many others.

[6] All trainings in child psychotherapy recognised by the Association of Child Psychotherapists lean towards one set of theories, following, though not exclusively, either a Kleinian or Winnicottian perspective. It is assumed that the literature outlined in this review faithfully adheres to the tradition of thought followed by UK trained Child psychotherapists and concept described would be familiar to ACP registered child psychotherapists working with children under 5.

I then broadened my search to locate psychoanalytic literature relating to the working with or understanding of infants, children, dynamics with their families and work undertaken with the wider networker of related services. Here, the objective was to explore the breath of applied work that child psychotherapists might engage in, whilst still adhering to similar set of psychoanalytic principles. The electronic database 'EBSCOhost' was used to locate relevant literature for this review. As this research focuses on psychoanalytic approaches and considerations, the 'Psychoanalytic Electronic Publishing (PEP) Archive' was deemed the most suitable database to conduct my searches through. Reading lists for 'Infant observation' and 'Infant mental health' modules from two prominent psychoanalytic trainings also supported in directing my attention towards relevant literature or authors.

Infant mental health is a vast field, and some careful consideration of what to include within this review has taken place. Most of the literature in this review is authored by child psychotherapists of the British Object relation (BOR) persuasion and has direct relation to working with or understanding children under 5 years old. The contributions of Selma Fraiberg, an American child psychoanalyst, and later key contributors to the development of Parent Infant Psychotherapy are exceptions to this. Their work has been included in this review as it is regularly referenced by BOR child psychotherapists and is understood to have informed the work of BOR child psychotherapists working in this specialism. Similarly, a small number of references to books or papers authored by adult psychoanalysts, and professionals with additional psychoanalytic expertise have been included as they helpfully illustrate some aspect of the role a psychotherapist might play.

2.3 How do child psychotherapists think about small children? Contributions to psychoanalytic theory relating to infancy and early childhood.

2.3.1a. Babies and their mothers - Classical literature

In the early decades of the 20th century, a new generation of British based analysts sought to expand the practice and theory of psychoanalysis to include models of understanding and working with infants and young children, laying the foundations of

the contemporary discipline of Child Psychoanalytic Psychotherapy. Melanie Klein's contributions to this field were vast. She held that human being related to each other from birth and developed 'Object Relations Theory', a comprehensive theoretical framework, to support this view.

The theory emphasises the importance of a baby's earliest experiences with his[7] mother, both real and those occurring unconsciously in phantasy, starting with his relationship with the breast. This is a relationship of such enormous importance due to the role that the feeding breast plays in sustaining a baby's life. Renouncing the myth of the *"paradise of childhood",* (Klein 1932, p.3), Klein viewed the 'normal' infantile experience as one brimming with anxiety, which was initiated at the start of life through the trauma of birth and the separation it brought about. She held that in early infancy, physical discomfort in the form of the *"frustration of bodily needs",* (Klein, 1946, p.5) such as hunger was inseparably bound up with psychological discomfort and anxiety. A baby would experience these bodily needs, sensations, and the loss of bodily equilibrium as a privation, a sense that something was missing or lacking. This rhythm of frustrations gave rise to extreme and often conflicting emotions in a baby such as love and hate towards the much needed but sometimes absent breast, frustrations when needs were not met, fear, greed, anxiety, and aggressive impulses.

Klein held that at the onset of his psychological development, these powerful and conflicting emotions were overwhelming for the young baby and were experienced as 'fragmenting' and threatening to their very survival. Thus, these emotions and impulses were managed psychologically by the baby through the use of the primary defences of 'splitting' - the psychic separation of conflicting impulses, emotions, or of good and bad aspects of the self, the object or one's experience, and 'projective identification' - the location of these 'bad' split off aspects into another, initially the breast and then the mother. This process also involved splitting the object (breast/mother) into two – 'good' and 'bad'. Klein named this phase in infantile development the 'paranoid - schizoid position' (Klein, 1946). In ordinary development Klein viewed that this process allowed the baby to split off and rid himself of the 'bad' including his

[7] For grammatical simplicity, the pronoun 'he/him/his' will be used to denote an infant of either sex.

aggressive and greedy impulses towards the breast or mother, whilst retaining the 'good' around which later healthy ego development could build.

Klein believed that a baby would move through the 'paranoid schizoid position', where splitting and projective identification were in high operation, towards the 'depressive position' (Klein, 1946), where splitting decreased and the split off parts of the baby and the mother were drawn back together. In this position, the mother could be understood and internalised as a whole person and aggressive attacks made by the baby on the mother either in phantasy or in reality would then be followed by guilt and a desire for reparation. Through this, further ego development could ensue. Far from abnormal, Klein viewed these processes as normal within infancy, only becoming abnormal when the use of these primary defences became excessive, pathologically ingrained, or extended well beyond the developmental phases to which they belonged. She believed too that these positions were returned to throughout childhood and adult life and reworked, marking this as task that continued throughout life.

Klein's view of the early mental functioning of babies and young children places emphasis on the 'ordinary' baby as a being capable of having extreme emotions, of 'experiencing', 'feeling' and of having a mind. She implores her readers to view the baby as a human, who even in ordinary circumstances "*goes through an unmeasurable degree of suffering*" (Klein, 1927 p173), and to "*remember the helplessness of the infant in the face of internal or external dangers*" (Klein, 1948 p35). Through her extensive body of work, she draws attention to the minutiae of relating which a baby is engaged in from the onset of his life. Too, she emphasises the importance of both 'real', lived events occurring in the external environment and of the baby's perception and management of these events, detailing the turbulent internal world of young children, where boundaries between internal and external, self and other, and phantasies and reality are fluid and under development, marking the earliest months of life as highly influential to later psychic development.

As Klein's theories of infant mental functioning gained popularity, other analysts of the mid-20th century sought to add to and challenge Klein's view of psychic development in infancy. Whilst Klein's theories largely focused on the infant's internal world and internal representations of reality, students and contemporaries of Klein examined the

role that the external environment, the mother, and instinct played in the formation of the psyche during infancy.

Donald Winnicott challenged the lack of attention paid to the external environment within Klein's theories. He argued that "*it is not enough that it is acknowledged that the environment is important… in the earliest stages of life the infant and the maternal care belong to each other and cannot be disentangled*" (Winnicott, 1960 p.40). Considering very young babies, Winnicott presented a view of the mother and infant dyad as a single unit, suggesting that a baby was not a separate 'self' but had complete dependency on the mother and on her care. As such, Winnicott viewed that the quality and availability of a mother's care was of great significance. Winnicott held that in normal circumstances, a baby would be cared for by a mother that was able to respond to his needs reliability, and that this would support him in moving down the path of normal development. He emphasised that seamless attunement to a baby's needs was not necessary and that "*good enough*" mothering (Winnicott, 1953, p.13) was sufficient. However, if needs were frequently not met or met in a mechanical way which lacked attentive responsiveness from mother to baby, normal, healthy psychological development in infancy might not be achieved.

Further to this, Winnicott introduced an alternative view of stages within infancy (Winnicott, 1960) whereby a young baby moves from contented and cocoon-like 'absolute dependence', a state of interwoven dependence with the mother, towards 'relative independence'. He introduced the term 'Primary maternal preoccupation' (Winnicott, 1963, p.85) to describe an ordinary mother's attentive and hypersensitive focus on her baby in the first months of life and described the state of omnipotence that a baby would experience in an environment that responds to his needs. He viewed that gradually, as a mother and baby disentangled, the environment shifted from one that existed for the baby to one that existed independent from the baby. The baby would then be met with the objective reality of being separate from their mother or of waiting longer for needs to be met and the baby's former sense of omnipotence would undergo some disillusionment. Winnicott viewed that it was essential that a baby was allowed to have an adequate experience of 'absolute dependence' in order for the early ego to develop and strengthen. If a baby's needs were not met during this time, he would be forced to become aware of the environment and disillusionment would come too early

or else too abruptly. The extent of the impact of such an ego weakening experience would depend on the extent and regularity of moments of early disillusionment, where the baby is knocked out of the cocoon like comfort of absolute dependence.

Like the emphasis that Klein placed on the role of the feeding relationship in earliest development, Winnicott emphasised the importance of the relational experience of 'holding' (1960, p.43) and of the infant's experience of 'being held'. To Winnicott, 'being held' encompassed several experiences, including a baby being held physically and being held in a stable environment, through the rhythm of regularly having needs met. 'Holding' also related to a mother's psychological capacity to hold her baby in mind and to be able to 'hold' her baby's emotions and communications, to think about these communications and to respond accordingly. Winnicott suggested that this capacity should not be assumed to exist naturally in all mothers and depends both on the mother's capacity to bear and respond to the communications, needs and frustrations of her baby as well as her capacity to tolerate her own frustration towards the baby. Indeed, Winnicott held firmly that ordinary mothers were quite capable of feeling hatred towards their infant but suggested that a *"Mother has to be able to tolerate hating her baby without doing anything about it."* (1949, p.73)

Wilfred Bion, a student of Klein and contemporary of Winnicott focused his attention on the development of thought and thinking throughout early infancy, outlined in 'A theory of thinking' (Bion, 1962). Bion also understood the underdeveloped state of the infantile mind, a mind in which un-processable frustrations and anxiety, aspect of the baby's sensory experience and being, described as 'beta elements' were not able to be tolerated by the baby's mind and thus needed to be evacuated. He considered though that the purpose of such evacuations was not simply to rid the intolerable from the mind but was an infant's attempt to locate the intolerable in another (the mother's) mind who, through her attention and 'reverie' (1962, p.36), would then be able to understand something of her baby's distress, and thus was a means of preverbal communication. 'Alpha function' (Bion, 1962, p.35) is used by Bion to describe the mental function of a mind in collecting the unprocessed and unlinked 'beta elements' and transforming them more coherent 'alpha elements' which were available to be thought about, stored, or repressed. With some similarities to Winnicott's 'holding', 'container – contained' (1970, p72) is used by Bion to describe the way a mother might use her mind to

'contain', (take in) the uncontainable and intolerable aspects of her baby's experience. By doing so the baby's discomfort is received by the mother and he would experience a sense of being both understood and 'contained'. Through repeat experiences, the baby would internalise the capacity to 'contain' and manage emotions and would gradually develop the ability to tolerate and manage their own internal turbulence in a regulated way.

Differing focuses and challenges to the Kleinian perspective were a source of division within the British based psychoanalytic community, and contributed to a tripartite division of the British psychoanalytic society following the 'controversial discussions' of the 1940's. Bowlby's later held views on infantile development, developed in the 1950's and chronicled in the trilogy *Attachment and Loss* (Bowlby, 1969-80) placed greater emphasis on the environment and proved perhaps the greatest challenge to the Kleinian perspective. His ideas, which formed the basis of 'Attachment Theory' (Bowlby, 1969) were met with strong opposition within the British psychoanalytic community (Gullestad, 2001) and were generally considered too divergent to fall under the umbrella of psychoanalytic theory.

Despite their different focuses, convergence and similarities can be found within these core psychoanalytic ideas relating to infancy. Generally, they highlight the importance of the baby's relational experiences in their earliest months and the impact that the patterns of relating established within these months have on later relating, both to others, the environment, to and within oneself, and to objective reality. Theorists indicate that ego development begins in infancy and that experiences in infancy form the core of the ego around which later psychological or psychical development can organise itself, marking relational experiences in infancy as influential to psychological functioning throughout life. Viewed together, there is a general trend in psychoanalytic thinking around infancy to consider the interplay between the infant's internal world, the mother's mental state and capacity, the infant's disposition and to a lesser or greater extent, the external environment. All theorists indicate that anxiety and the management of anxiety during infancy is of vital importance and will set in motion the psychological capacity of the infant to tolerate anxiety, or else, when circumstances are adverse, the formation of rigid patterns of defending against anxiety. These early theorists also pay tribute to the place of aggression and hostile feelings in early infancy, which includes

the importance of a mother being able and willing manage her own and her infant's aggression and to play a compassion function for their infant. A nuanced consideration of Klein, Bion and Winnicott's perspective on infancy and on the interplay between love, attachment, destructiveness, and aggression can be found transcribed panel discussions by Britton, Chused, Ellman and Likerman (2006)

2.3.1b. Babies and their mothers – contemporary literature

Building and expanding on the psychoanalytic concepts established by early psychoanalysts following the British object relations school of thought, a plethora of further contributions to psychoanalytic theory and thinking around infancy have been made. These contributions highlight the importance of relational experiences in infancy, documenting signs and impact of adverse experiences in infancy. Quite often, using the psychoanalytic theoretical framework, these contributions also provide insight into the early origins of these difficulties and into ways in which they might be reduced by intervention from child psychotherapists.

Bion's concept of maternal 'containment' has been revisited by many contemporary authors who provide insight into the impact of a lack of adequate containment in infancy and circumstances that might precipitate this. Bick (1968) uses the term "second skin containment" (1968, p.484) to describe the need for a baby, faced with a severe deficit in containment, to resort to defensive self-containing behaviours such as excessive muscular tension or sensory stimulation to hold himself together. Other signs of pathological defences in infancy due to lack of containment have also been documented. Fraiberg's (1982) observational study of infants subject to deprivation and neglect identified gaze avoidance, freezing and fighting as early indicators in infancy. The likelihood of these defences become entrenched or pathological may depend on the severity, duration, or regularity of the deficit of containment. Re-exploring Bick's concept of 'second skin containment', Cornwell (1983) notes that subtle signs of this presentation were also seen to exist in infants faced with more ordinary losses of containment, such as the loss of a mother's focus due to the birth of a younger sibling.

Considering the continuing impact that adverse early relational experience may have in toddlerhood and early childhood, Emanuel (2003) describes that patterns of relating established in infancy will continue and begin to show themselves in the personality of a young child. She details the escalation of negative relational cycles whereby toddlers might respond to repeat experiences of lack of containment by enhancing behaviours designed to elicit containment from their parent, for example, placing themselves in risky situations or else by becoming increasingly withdrawn, suggesting that the infant's temperament may play a part in how they respond to a lack of containment. She notes too that both presentations bear similarity to behavioural, social or communication difficulties such as autistic spectrum disorder or ADHD. In a later paper, Emanuel, (2012) also links a lack of early containment of an infant's overwhelming somatic states to presentations of somatic difficulties such as constipation and enuresis in later infancy and early childhood.

Further consideration has been paid to the interwoven nature of bodily experiences and the mind in infancy. Writing on the subject, Miller (1999) outlines three basic needs of the baby; 'feeding', 'holding' and 'cleaning up', which all have their *"psychological concomitants that are no less vital to the health survival of the infant"* (p.34). Along with physical care needs being met, infants are psychologically nourished through the experience of a good feed, held in mind by their mothers and emotionally 'cleaned up' after when emotions overwhelm. Daws (2008) draws a link between apparently somatic issues of disturbed sleeping and feeding and emotional disturbances in infancy. Echoing Klein's sentiment, she holds that *"early feeding is about the realities of life and death; it also about emotions that have the force of life and death"* (Daws 2008, p.245). She goes on to describe that the feeding relationship will likely stir up a new mother's infantile emotions, which may compound the difficulties in the feeding relationship. In addition, she considers the interrelated nature of feeding and sleeping difficulties with separation difficulties, illustrating ways in which relational or emotional difficulties may present at first sight as somatic disturbances.

Considering the intrapsychic nature of containment, Williams (1997) suggests the term 'convex container with a spout' to describe a damaging kind of containment in reverse, whereby a baby is projected into and becomes the container for their mother's unwanted or intolerable feelings, an experience that would be psychologically

damaging to the baby. Exploring a phenomenon at the other end of the relational spectrum, Hopkins (1996) describes the potentially damaging relational experience of a baby cared for by a 'too good' mother, attuning too closely to their needs and thus not allowing room for ordinary differentiation and frustration to occur. Hopkins suggests that a baby in such a position might develop a rejecting pattern of relating to their mother, or else might become merged and enmeshed with them, entering a state of arrested development. These concepts illustrate the ways in which the presence of maternal mental health difficulties may adversely impact an infant.

Contemporary authors have also focused their attention on the phenomena of transgenerational trauma, considering the birth of a new baby into the family as a stirring time for parents. Fraiberg's (1975) paper *Ghosts in the nurseries* draws attention to ways in which the parenting couple's past, particularly their own childhood and unmet infantile needs, may live on and 'haunt' the present, impacting parents' perceptions of their infant and capacity to meet their needs and may present themselves as symptoms in the infant. In a similar vein, Seglow and Cannon (1999) consider *"Intra-uterine life and the experience of birth"* reflecting both on the developing baby and on the complex process of change that those becoming parents go through, considering this process to be stirring and likely to awaken aspects of the parent's past and their own constellation of internal objects.

Other authors have considered the experiences of fostered and adopted children who have suffered breaks in attachment and prior to this often-extended periods of abuse and neglect. Such authors describe the early internalisation of chaotic relational patterns in infancy and experiences of being *"dropped"* (Edwards, 2000) rather than held, which are carried by children and are likely to play out in subsequent relationships even when children are placed in caring homes with responsive carers. Kendrick (2000) notes that, *"later experience can reactivate earlier catastrophic anxieties.",* as *"given early experiences of deprivation and abuse and lack of containment both at external and internal levels, these are children who have found themselves alone and unable to process or to attach meaning to experience."* (p.393). In line with this, Cannon (1999) describes that for some adopted children, *"Infantile aspects of the personality, such as the desire to be held and fed and cleaned, are not properly satisfied, and the child*

moves into latency and on to adolescence with all the earlier stages of development impacting on subsequent ones." (p.126), detailing again the longitudinal impact of deprivation in infancy.

2.4 Moving from infancy to early childhood.

Moving out of the mother – infant dyad of babyhood into early childhood comes with a set of ordinary but challenging tasks relating to a toddler finding their place within the family and particularly, their place in relation to the parental couple. This was first characterized by Freud's (1910) conception of the 'Oedipus complex', referenced and developed by Klein in her descriptions of the 'Oedipus situation' (Klein 1928) and by others as the 'Oedipal triangle' and 'triangular space'. (Britton, 1989). In all its forms, the Oedipus complex remains a cornerstone of psychoanalytic theory and *"the daily currency of our work in various forms."* (Britton, 1992 p.35)

Taking centre stage when first encountered by infants between the ages of one and 4 years old, it involves coming to terms with and tolerating the relationship between the parental couple, a relationship that exists independent from a young child. Britton (1989) suggests that *"The initial recognition of the parental sexual relationship involves relinquishing the idea of sole and permanent possession of mother and leads to a profound sense of loss which, if not tolerated, may become a sense of persecution. Later, the oedipal encounter also involves recognition of the difference between the relationship between parents as distinct from the relationship between parent and child… this recognition produces a sense of loss and envy, which, if not tolerated, may become a sense of grievance or self-denigration." (p.84-85)*

In addition, Britton (1992) links developments occurring through encountering the Oedipus situation with developments in the depressive position, noting the positive aspects of this development, such as the capacity for greater self-awareness and the opportunity it provides to be observed in a relationship and to observe a relationship that one is not part of. Cannon (2003) also considers the importance of a young child's relationship with their parents, commenting that this, *"sets the scene for how [they] deal with many areas of emotional life: feelings of smallness and exclusion in relation to the parental couple; questions about how [they] were created; the nature of the link*

between two people; the differences between a child and an adult. All of these are explored within the triad created between mother, father and child. (p.6). These two considerations mark toddlerhood and the navigation of the transition from dyad to triad as a turbulent time for young children with the potential to seriously impact on their internal world and emotional growth. These considerations also serve to highlight how the parental relationship and structure or dynamics within the family may support or derail a young child's capacity to progress through this challenge.

2.5 Observing infants – experiential learning in the training of child and adolescent psychotherapists.

Building on the theoretical groundwork laid by those following the British object relation school of thought, further developments in the clinical training of child psychotherapists and in models of working with young children have influenced the modern-day practice of child psychotherapists. Amongst these was the introduction in 1948 of the 'Infant Observation' module as part of the Kleinian training for child psychotherapists. In the 1960's this became part of preclinical training, was soon adopted by other training schools across the UK and remains a prerequisite for entry onto the clinical training today.

The module, introduced by Ester Bick, sees students undertake a weekly observation of a baby within their family and home environment from the first weeks of life up until their second birthday. Students are directed to pay close attention to the interactions of the baby with their caregivers and to consider the *"creation of the infant's personality, the interactions between constitutional and temperamental factors in the baby and the particular strengths and weaknesses of the holding environment"* (Rustin, 1989 p.7). By undertaking their own observations and through having the opportunity to benefit from the observations of others within their seminar group, students learn first-hand about the intricacies of emotional development in infancy.

A further important aspect of the infant observation module is the requirement for students to take up and maintain the new and unfamiliar role of the 'observer', distinctly different from other professional roles that the student may be familiar with. Students may encounter challenges maintaining this role and might find themselves

being pulled out of role by the families they are observing or else, due to their own personal difficulties, might find themselves dropping or distorting the role, or else acting into some or other dynamic within the observed family. Indeed, Rustin suggest that *"The guiding principle… is the importance of resisting acting out a role which involves infantile transferences between observer and family members, in either direction, whilst being present in the moment as fully as possible, open to perceiving as much as possible."* (Rustin, 2009 p.30)

Holding this position is not always a comfortable or straightforward experience and can stir up emotions within the observer (Daws 1999). Holding the position requires the students to learn to separate out their own anxieties from those of the baby's as well as the observed parent/s, who may also find themselves thrust into a new role as parents or else adjusting to the shift in dynamic within their own family. Whilst the emotions stirred up in the observer might need some careful unpicking, they are considered a valuable source of data within the observations. Indeed, when describing 'Infant observations' Miller (2008) holds that *"the truths that interest us are the emotional truths. The observer cannot register or record them without being stirred."* Miller goes on to describe that *"we are asking ourselves not only to observe what appears to be happening but also to observe the effect that it is having upon them"* This two-year experience forms the basis of a fledgling therapist's capacity to register and understand transference and countertransference, an important clinical tool for qualified child psychotherapists.

Outlining the rationale for the inclusion of an infant observation within the preclinical aspect of the training, Bick (1964) makes clear the benefits of this experience for those continuing to train as child psychotherapists. She suggests that the observation would prepare students to later understand and conceive of the infantile experience of their child patients and would increase a student's ability to understand non-verbal behaviour and play of their child patients, as well as the meaning behind and behaviour of a child that does not speak or play. Too, she believed that this experience would support a child psychotherapist in taking full histories of their young patients when meeting with their parents, and in understanding the significance of these histories. Reflecting on the benefits the experiential learning opportunity afforded by conducting an infant observation, Rustin draws a distinction between intellectually knowledge accrued

through "learning about" something and a deeper type of knowledge, *"akin to the Biblical sense of 'knowing', being in touch with the core or essence of something or somebody"* (Rustin, 1989 p.8), further outlining the value and importance of the learning experience gained by undertaking an infant observation.

2.6 From theory to practice; working psychoanalytically with children under 5 and their families.

Core theories and considerations on infancy and early childhood have shaped the way that child psychotherapists work with and understand their very young patients. Klein introduced the use of a toy box in therapy with young children, understanding that *"play is a child's most important medium of expression"* (Klein 1932, p.8). Child psychotherapists share a core belief that symbolically through their play a child might represent aspects of their internal world and object relations, and this along with the way in which a child relates to their therapist and their environment holds meaning, can be understood by the therapist, thought about and interpreted.

Bion's and Winnicott's conceptions of the 'containing' and 'holding' role that a mother and the environment might usefully play in infancy are also used to describe the similar role that a child psychotherapist and the environment in which the therapy takes place in, traditionally the consultancy room, play for their young (and indeed older) patients. It is well understood that an aspect of psychotherapy includes sessions being offered at the same time of the week, in the same place, creating a rhythmic holding environment for patients. The therapist also provides an intrapsychic holding and containing function for their patients by being available to take in, hold and think about the intolerable emotions and aspects of the patient without becoming overwhelmed by them. Therapists thus play a similar psychological function to that of a normally heathy mother, including the capacity to withstand negative projections and hostility.

Over recent decades child psychotherapists have explored and developed novel ways of working with young children. An important addition came in the form of the development of methods of brief intervention with infants, young children and their parents detailed in Bradley and Emanuel's (2008) '"What can the matter be?"

Therapeutic interventions with parents, infants and young children', which explores 20 years of therapeutic interventions offered within the Tavistock Clinic in London. The approach was noted to have developed in part from child psychotherapist Martha Harris' work, where she began to offer "therapeutic consultations" to parents with babies or young children, detailing in her 1966 paper *A 3-session therapeutic consultation spaced out over the course of several weeks*. She observed that the approach of offering no advice or interpretation but by simply meeting a few times with the family, observing, listening, and giving voice to some of the difficulties that family members were experiencing served to relieve some of the difficulties expressed by and observed in the family.

What developed out of this early, time-limited approach was the Tavistock under 5 service, offering *"quick response, psychoanalytically based interventions to families"* (Bradley and Emanuel 2008, p.1), with the aim of providing short term (initially 5 sessions) interventions to families with young children who were experiencing difficulties. Flexibility and responsiveness were key components of the work, with frequency of the sessions and duration of the intervention remaining unfixed. Within this intervention, young children were seen with their mother or parents, and were sometimes joined by siblings or other members of the extended family. The work would begin with no set structure in mind, and decisions about the nature of the intervention could be made based on clinical judgment. Bradley and Emanuel suggest that flexibility in work is important and *"possible when the therapist has an internal theoretical framework on which to draw, enabling her to provide a containing structure to the interventions."* (2008, p.6-7) Thus, the 'structure' within this intervention can be understood to come from the therapists 'way of seeing' based on theoretical understanding, and capacity to provide containment.

When describing the nature of the work, Bradley and Emanuel (2008) detail that *"The therapist will attempt to make contact with the infant or child, observing his play and attempting to understand the meaning of his communications whilst also engaging the parent"*. (p.6) They expand that engaging the parents is "*likely to include the gradual exploration of parental background and its implications for the family"* (p.6). Isca Wittenberg, a child psychotherapist also working within the Tavistock under 5's service, describes the importance of such early interventions, expressing that, "*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 to the first order" (p.18). Barrows (2008) offers further insight into brief working with parents and young children, suggesting that, *"the capacity to reflect, to think rather than to act, to maintain an attentive presence in the face of overwhelming projections is central to this work."* (p.78)

Noted by many clinicians within the service was the speed of change that appeared possible, where shifts in the presenting difficulties were noted after only a few sessions, a phenomena documented and discussed in *The process of change in under – five work* (Barrows, 2008) and in *A slow unfolding -at double speed: therapeutic interventions with parents and their young children.* (Emanuel, 2008). Noting the benefits of brief work with parents and infants, Wittenberg (2008) suggests that it does not *"encourage dependency and… avoid[s] the danger of disturbing the new intimate relationship developing between parents and their offspring*" (p36). Barrows (2008), however, notes that effective brief intervention is dependent on having clients *"who can make good use of a brief intervention"* (p70), and may not be an effective intervention for the *"very deprived, high-risk, multi-problem population."* (p.70)

The links between short term interventions with young children and parents practiced and documented by contemporary child psychotherapists and concepts in classical psychoanalytic theory or training are clear. Indeed, almost all authors on the subject reference Kleinian, Bionian and /or Winnicottian concepts as the theoretical underpinning of the practice. Emanuel pays particular focus to this in her paper *Holding on; being held; letting go: the relevance of Bion's thinking for psychoanalytic work with parents, infants and children under five* (2012). Miller (2009) too, uses the Bionian term 'without memory and desire' to describe the mindset that a clinician ought to approach under 5's work with, stating; *"we need open minds, free on each new occasion from hampering preconceptions, able to see what is there even if it disquietingly fails to fit in with what we expect. We must not be too eager to see our wishes fulfilled whether these wishes are to have our theories corroborated or to see the families we observe or treat turned out to be the kind of family that would give us pleasure. We have to try to see things as they are."* (p.53)

Many authors have also drawn clear links between learning accrued whilst undertaking the infant observation and later clinical work with young children, suggesting that, *"at the heart of the framework is the application of observational skills to clinical work with families with young children"* (Bradley and Emanuel, 2008 p.3). Similarly, Wittenberg (2008) suggests that, *"Infant observation also helps one to study one's own feeling in response the triad of baby, mother, and father. We need to become aware of the strength and nature of the emotions invoked in us in order to empathise with the parents and infants and not to allow prejudices and judgmental attitudes to interfere in our professional work."* (p.19)

Aside from the Tavistock under-fives service, other models of working psychoanalytically with parents and young children have developed. Closely linked to the practice of infant observation was the development of 'therapeutic observations' as an intervention, in which experienced observers engaged in observations with infants and parents / carers struggling with a range of complex difficulties. Reflecting on her research into the use of therapeutic observation with an infant in foster care, Wakelyn (2011) suggests that such observational intervention can provide "*an effective voice at a crucial stage in care planning"* (p.72)

A further, influential intervention for parents and young children was Selma Fraiberg and colleagues' 'Infant – Parent psychotherapy' (Fraiberg and Fraiberg, 1980) developed from work in America with deprived mothers. Early stages of the development and accounts of this approach is outlined in *Ghosts in the nurseries* (1975) and *Infant - parent psychotherapy on behalf of a child in a critical nutrition state* (1976). Like Winnicott, Fraiberg viewed that there was no such things as individual psychopathology in infancy, and viewed that a baby's pathology was intrinsically interwoven with their mother's. She observed that babies and young children could become receptacle for unwanted aspects of the parent or parent's past, which interfered with the parent's ability to bond with their baby or to provide adequate care (Fraiberg 1975), a view later supported by findings from an empirical study conducted by Fonagy et al. (1993). Fraiberg outlined the need for infants and parents to be seen together for treatment. Reflecting on this approach, Hopkins (2008) describes that, *"Symptoms in the infant can best be treated by treating the infant – parent relationship"* and that,

"the infant's presence [in the session] ensures that parental feelings towards him are readily available in the here-and-now for exploration and interpretation" (p.54).

Fraiberg's conception of Parent – infant psychotherapy has been developed extensively by clinicians working within the UK into the therapeutic model PIP (parent -infant psychotherapy). Accredited trainings in PIP are help in a number of locations in the UK and PIP is recognised and promoted as a treatment for disturbances in the parent – infant relationship. In 2016, Dr Jane Barlow and colleagues conducted a systematic review comprised of 8 studies which assessed the effectiveness of PIP when compared with 'no treatment' groups. The authors concluded that although "*PIP is a promising model for improving attachment security in high-risk families… there was no evidence that PIP is more effective than other methods of working with parents and infants"* (2016 p.9). Whilst aspects of PIP bear similarity to the practice of child psychotherapists working with parents and infant and is an additional training that some child psychotherapists working in this specialism may choose to do, it and other related interventions such as 'Watch Wait and Wonder' is not part of the core training for ACP registered child psychotherapists. Though these therapeutic models are likely to be of interest to child psychotherapists working in this specialism, it is beyond the scope of this review to discuss them further.

Building on and following in the tradition of the Tavistock under 5's service, child psychotherapist Maria Pozzi provides an expansive and detailed description of psychoanalytic work in her book *Psychic Hooks and Bolts, psychoanalytic work with children under five and their families* (2003) detailing the provision of short-term psychoanalytic interventions to young children and families within the consultancy room. She helpfully details the techniques used and describes the importance of the physical setting and the mental setting, that is, the analysis mind, suggesting that *"the function of the analyst is similar to that of the mother who is receptive and open to receive and contain what the baby expresses in terms of bodily and psychological states and needs. The analyst picks up what is presented openly and also what is concealed and unconscious to the patient and tries to make sense of it in his mind"* (2003, p.35) Within her book, Pozzi details working with a vast range of difficulties and disorders in both infants and young children as well as those in the parental couple, providing clear case example where families are helped to think about issues such as separation and

loss, post-natal or maternal depression, eating, sleeping, soiling, and learning or behavioural difficulties. When describing psychoanalytic work with parents and young children, Daws (1999) offers "*it cannot be done in a routine way; the impact of each family's stress and bewilderment must be received afresh each time."* (p.279)

2.7 Out of the consultancy room; applied psychotherapy, intradisciplinary working and psychoanalytic consultation to the network.

'Applied psychoanalytic work' is used here to describe work with under 5's and families which takes place outside of the traditional setting of the consultancy room, but that remains psychoanalytic in its approach. Within the literature, many examples can be found of psychoanalytic interventions taking place in a host of different locations. Both Daw (1985, 1999, 2005) and Tydeman and Sternberg (2008) document their work in GP's centres and Emanuel (2008) describes working with families and toddlers in a children's centre. Fraiberg (1975) describes conducting *"psychotherapy in the kitchen"* (p.394) within the patient's home and similarly, in Wakelyne's (2011) study exploring the use of therapeutic observation as a mode of intervention, observations were carried out within patients' homes.

The rationale behind of offering psychoanalytic interventions in the community include the observation that *"parents will approach their GP with a number of problems for which they would never imagine needing referral to a psychological service or hospital department."* (Tydeman and Sternberg, 2008, p.99) and that it can facilitate *"targeting families who were unlikely to find their way into child and adolescent services"* (Emanuel, p.136). Daws (2005) suggests too that *"work in a baby clinic enables families to get help with their infant's development as early as possible. The hope is that later difficulties in the relationship between parents and child may thus be forestalled"* (p.21)

Further benefits of applied or 'outreach' work include the ability to work with professionals of different disciplines, including close contact with and ability to provide informal consultation to point-of-first-contact professionals such as GP's and health visitors (Daws 1999, 2005). Daws does however note the difficulties in such work, suggesting that certain qualities such as a *"very thick skin"* (2005 p18) are needed

when working in an institution that is not one's own. Reflecting on the difficulties of holding her place in a baby clinic, within a GP practice, Daws (2005) suggests, *"Having outsiders around can make a group feel uncomfortable. Being an outsider in such a group is uncomfortable",* (p.20) suggesting that an aspect of the discomfort is knowing where to position oneself, both amongst other professionals but also, quite literally, within the GP surgery.

Fairly frequently child, adolescent and adult psychotherapists have sought to engage in supporting other professionals within the health or social care network by providing supervision or consultation. This can take the form of more formalised weekly or monthly supervision or work discussion groups with groups such as psychiatric nurses, nursery workers, social workers, GP's etc. Authors also describe informal points of supervision or contact with other professionals of a sort of 'corridor consultation' nature where, within unscheduled discussions, a psychotherapist might lend their way of seeing a particular clinical issues and support others to see things differently, exemplified in Daws' (1999) description of co working with GP and health visitors within baby clinics. Formal weekly supervision and consultation of health visitors is also well documented within this paper.

Both Pozzi's (2003) *Consultations to a nursery school* and Elfer and Dearnley's (2007) research study '*Nurseries and emotional well-being: evaluating an emotionally containing model of professional development'* address the subject of providing psychotherapeutic consultation and supervision to professionals working in nurseries. Both highlight the benefits of such work, where shifts in staff capacity to think about emotional wellbeing are present following attendance to a 4 sessions CPD course (Elfer and Dearnley, 2007) or to a longer period (11 sessions spaced over 21 months) of supervision 'space' for staff within the nursery. However, both too describe difficulties and resistances that the staffing group could display in relation to engaging with the intervention and with the task of thinking more deeply about the emotional wellbeing of the children under their care.

Further descriptions of the provision of consultation to the professional network described by psychoanalysts provide some insight into the reported difficulties in providing supervision and support where it might well be needed. Reflecting on her

work providing consultations for social workers, Emanuel (2008) suggests that "*It is often difficult for staff, unaccustomed to the opportunity to stop and reflect on their work, to remove themselves from the relentless pressure of work, to think about a case"*

Further child and adult psychotherapists have considered the pressures that front line staff might face, which may hinder their capacity to make space to think about the work they are engaged in. This pressure is seen to come not only from the everyday high demands of the work but is also exacerbated by complex unconscious dynamics at play when working with vulnerable, complex, or unwell patient groups, where the intense anxiety, hostility and trauma of the patient group can be emotionally stirring, hard to understand and significantly impact and influence a professional's, team's or network's capacity to function and think clearly. When reflecting on her work with professionals working within a baby clinic Daws (1999) described that psychotherapist's can play an important role in supporting other professionals in thinking about the intense feelings stirred up in them and in supporting professionals in digesting and understanding these feelings.

Authors raise concerns that, when no space is provided to reflect on the work undertaken, complex and powerful unconscious dynamics in the patients may lead to the risk of *"re-enactment as an unwitting professional response to family dynamics"* (Britton, 1981, p.49), "*ridged split[ting]and scapegoating"* within teams or networks (Pozzi, 2003, p.191), or professional paralysis in the face of the "*often conflicting demands of patient, parents and children as well as conflicting demands from their manager"* Emanuel (2002, p.174). Stating the case for the need for greater support, training and above all, space to think for front line professionals, Evans (2020) suggests that a *"lack of training which might be able to provide a clinical model that helps clinicians make sense of unconscious dynamics, can leave professionals poorly equipped to deal with underlying psychological pressures inherent in their work"*, (p.23)

2.8 Summary

This review of relevant literature considers the theoretical underpinning to the approach of child psychotherapists held both by those working in the under 5's specialism as well

as those working across different specialisms within the discipline. The review then considers aspects of the clinical training (with particular focus on infant observation) and contemporary clinical writing which may be of particular relevance to Child psychotherapists working in the under 5's specialism.

The theoretical and conceptual underpinning along with a subscription to shared principles of psychoanalytic psychotherapy are sometimes referred to as the 'frame' or 'analytic frame'. This review highlights ways in which Child psychotherapists working in the specialism of under 5's have, through use of this frame, developed and implemented applied approaches and brief intervention models of working with children under 5, their families and the professional networks around them. Relevant literature demonstrates that this frame can and has been applied in numerous ways, across different settings.

Unavoidably, most clinical writing needs a focal point, and thus, papers which relate to the activity of child psychotherapists working with under 5's tend to focus on particular aspects of the role (such as the clinical work itself) with other aspects of the role acknowledged but left without in-depth consideration. Notable amongst the aspects of the role that are acknowledged but not often focused upon are the challenges and conflicts within the role, which may relate to the clinical work, working with other professionals or the emotional demands of the work. An attempt has been made within this review to consider challenges that may exist in the roles of front-line professionals working with complex patient groups. Writing on this subject tends to be written from the position of the psychotherapist taking up the role of consultant to a network that they themselves are not necessarily part of.

This research hopes to examine all aspects of the role that child psychotherapists play or take up in relation to their work with children under 5 and though doing may shed light on some of the complexities and competing demands within the role or that are present when working as part of a network of professionals rather than consulting when separate to it. This review demonstrates that, over time, the working patterns and preoccupations of child psychotherapists working in this specialism are liable to change, which may be due to a combination of natural evolution of the discipline, or to external changes and pressures in the organisation in which child psychotherapists

work. Thus, this research hopes to provide a 'snapshot' of the current conceptualisation of 'role' held by child psychotherapists working within this specialism.

3 Methodology

3.1 Design

Within this small-scale, qualitative research project, I collected data through conducting semi-structured interviews with Child and Adolescent Psychotherapists who were engaged in supporting with children under 5 years old and their families.

3.2 Participants

I interviewed seven child and adolescent psychotherapists within this research. Within the small profession of Child Psychotherapy, only a fraction of clinicians frequently treat children under the age of 5, with fewer still work in teams exclusively dedicated to supporting infants or children under the age of 5. As such, potential participants for this study were estimated to be few in number and difficult to trace. I initially attempted to trace participants for this study by locating specialist under 5 teams and sub teams both within and external to CAMHS across the UK. However, despite contacting several appropriate and prominent under 5's organisations, no national or regional lists of such services appeared to exist. Therefore, I recruited participants using a combination of purposive sampling and snowball sampling by first approaching potential participants based on their known eligibility to meet the inclusion criteria for the research. These initial participants then supported me in identifying others who may meet the criteria. 14 potential participants were identified and directly approached via email with an invitation to participate. I provided potential participants with written information relating to the study (see appendix C) prior to providing consent. Seven child and adolescent psychotherapists consented to take part in this study.

Inclusion criteria

- Participants sought for this study were required to have regularly worked with children under 5 years old as a psychotherapist for a minimum of two years.
- Participants were required to be currently engaged in clinical work with under 5's or their families either within specialist under 5's teams or sub teams, within parent and infant and family teams catering to children under 5, or with under 5's referred to 0-18 local CAMHS teams.
- Participants were required to have trained at one of the NHS approved training courses for the duration of their 4-year qualification, ascertained through their registration and full membership to the professional body 'The Association of Child Psychotherapists'.

Sample characteristics

I sought to include participants from all over the UK. Five women and two men were interviewed. They differed in age, number of years since qualification and in the positions they held within their teams, with two participants holding clinical and managerial positions in their services. Most of the participants were working within inner London, two in outer London and one working in another part of the UK. In terms of socio-economic background and ethnicity there was little diversity amongst participants; all participants were Caucasian, with English as a first language.

3.3 Procedure

3.3.1 Semi-structured Interviews

I conducted semi- structured interviews to collect the data. These interviews were designed to capture child psychotherapist's current working practice with children under 5, as well as their experiences and views of their role within this work. During my interview design phase, I conducted a trial interview with a child psychotherapist in training, working within an under 5's service. The answers and feedback from this trial interview supported in the reordering and rephrasing of several of the questions within the interview schedule.

The final interview schedule was comprised of nine questions, divided into two parts; Part A and Part B. Part A primarily sought to gather context and characteristics of the services that participants were working within. Part B predominantly aimed to elicit reflections and discussions about the participating child psychotherapists' thoughts and opinions on their work and the role they were engaged in. The final question in the interview addressed the core aim of the research and offered participants the opportunity to add any further comments, considerations or reflections which may be of relevance to this area of study. I provided participants with the interview schedule (See appendix D) 1 week prior to the interview taking place. This schedule included the list of questions that participants would be asked within the interviews. I informed participants that they were not required to make any preparation for the interview but may wish to consider the questions before hand.

Participants were offered the choice of an in-person interview either within the clinic they worked in, at the Tavistock and Portman Clinic, (though which this research has been approved) or via telephone. The interviews were conducted by the same researcher and lasted approximately one hour. The questions asked within the interview were of an open-ended nature which allowed for participants play a part in directing the flow of the interview. Some prompts were given to participants if needed. The interviews were recorded in full using and audio recorder and were then transcribed verbatim in preparation for analysis.

3.3.2 Data Analysis

The transcribed interviews were analysed using 'Thematic Analysis'. I used Brawn and Clarke's (2006) '6 phase guide' as the primary guide for this process. Thematic Analysis was chosen as a suitable method for analysing a person's perspective, experience or views or perception. Thus, it appeared a suitable method through which to address the core research aim. The credibility of this analysis was strengthened through regular supervision with my research supervisor during the period of analysis, when reporting the results of this research and when interpreting and considering the meaning of these results, detailed in the discussion section of this report. Supervision that took place during the period of analysis focused on the assignment of codes to the data set to ensure that the codes assigned faithfully adhered to the data collected.

Braun and Clarke (2006) suggest the 6 phases that a researcher could use when conducting a thematic analysis. These are,

- Phase 1 - Familiarising yourself with the data.
- Phase 2 - Generating initial codes.
- Phase 3 - Searching for themes
- Phase 4 - Reviewing themes.
- Phase 5 - Defining and naming themes.
- Phase 6 - Producing the report.

In line with phase one, once transcribed, I read through the interviews several times to allow for the data to become familiar. My initial thoughts and ideas that emerged during this process were noted down. The interview transcripts were then reformatted into a table format which included the interview transcript, a column denoting the 'key' for the coding and a blank column to mark the coding in as it occurred in the transcript.

Following phase two, I began to 'generate initial codes'. This was done by carefully reading and rereading the transcripts and by generating codes which captured the meaning or essence of small chunks of data from the transcript. This was an inductive process as the data was not approached with codes in mind, but the raw data of the transcripts was used to generate the codes. When new potential codes were generated, I marked them in the coding column next to the sections of transcript that they related to in an abbreviated form (e.g., Com), and added the full code (e.g. Community) to the 'code key' section (see appendix E for excerpt of initial coding on first transcript)

Once I had completed my initial analysis on the first interview, the code key, with codes generated from the first interview was transferred to the second interview transcript. The process was then conducted on the second transcript, allowing for both the same codes as found in the first interview and novel codes to be identified and marked. This process was then continued for all interview transcripts. A second rereading and coding of the transcripts then took place, allowing for novel codes generated in later read transcripts to be considered in relation to the data in the initial

transcripts. In this way, the data was analysed in an iterative cycle. Along the way, some codes were combined, separated into two separate codes, or renamed to reflect and represent the meaning of the data as faithfully as possible.

Once I had completed the initial stages of analysis, the analysis moved on to phase 3, 'searching for themes'. At this stage, the transcripts were set aside, and the generated codes were considered and grouped into broader themes. This was undertaken by clustering codes together and considering overarching themes which captured the essence of the group of codes. During this fluid process, codes were moved between clusters and reordered several times until they appeared to settle into groupings. During this process, I held the initial research question in mind, and themes that were generated through this process bore relation to and captured aspects of the question that this research aimed to address.

Phase 4 involved 'reviewing the themes' generated from the clustering of codes, and some further amendments and rearrangements took place. Whilst this process had a bottom- up quality to it, some decision-making originating from me as the researcher took place. In particular, the research question was considered and was influential in terms of how these themes were arranged and organised as it was essential to sift out information that was important and relevant to the initial research question and to separate out miscellaneous codes which did not seem connected to the question at hand.

During phase 5, themes became more clearly defined and themes were named. This included defining subordinate themes, each with their own set of subthemes. I then returned to the research transcripts, and I identified extracts and quotes from the transcripts that captured an essence of each the theme and subtheme. At this point in the process of analysis, I also considered the sequence that themes could be presented in, in order to present and navigate the data in the most straightforward way.

The final phase, phase 6, entailed 'producing a report' of the findings of the analysis. This report is outlined in the results and discussion section of this research.

3. 4 Ethics

This research was deemed to fall under the category of 'clinical audit'. (See Appendix A). Thus, local research and development ethical approval was sought and granted (See appendix B).

3.4.1 Informed consent and right to withdraw.

All participants gave their informed consent to participate in the study. They were informed that they were able to withdraw from the study at any point before or after the interview, without providing a reason.

3.4.2 Confidentiality/anonymisation procedures

Audio recordings of the interviews were transcribed, and transcripts were stored on a secure and encrypted device. During transcription, all identifying data within interviews such as names, location of services or other identifying details were omitted. Following their transcription, audio recordings of interviews were deleted. All data collected for the purpose of this research will be deleted following the final submission of this research project (Estimated date, December 2021)

3.4.3 Debriefing

Following the interview, participants were debriefed. They were given the opportunity to ask any remaining questions and procedures around confidentially and participants' rights to withdraw were verbally explained.

4 Results

4.1 Thematic analysis

The thematic analysis of the interviews of child psychotherapists participating in this study produced a variety of themes which encapsulated different aspects of their

understanding of their role when working with under 5's, their families and the network around them.

4.2 *Context.*

Psychotherapists interviewed for this study worked in a broad range of services which together catered for parents, infants, and young children from conception to 5 years old, with different services holding differing upper age restrictions for the referred child. Funding for services came through different routes, and included charity funding, central government funding, local authority, or NHS funding as part of a larger CAMHS team.

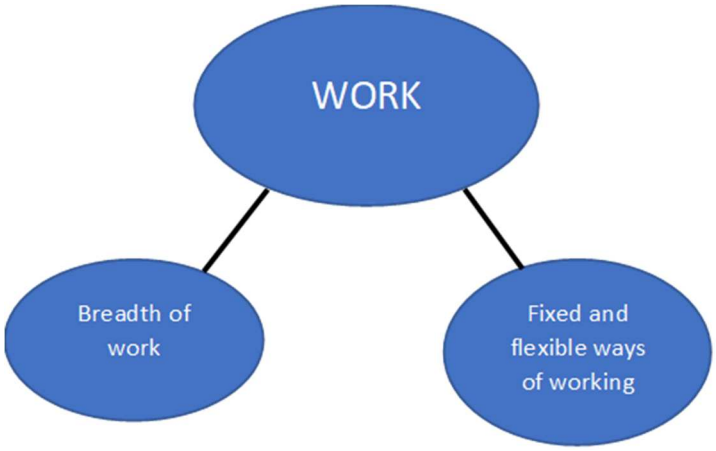
Teams tended to be small and part of a limited resource, often the only resource for infant mental health care within the district. Some interviewees were the only child psychotherapy presence within their team, whilst others worked in partnership with other child psychotherapists. The majority of services described were multidisciplinary and only one was child psychotherapy led.

4.3 Superordinate themes

Within this study, child psychotherapists were asked to consider and reflect on their role when working with under 5's, their families and the network of professionals around them. Analysis of the resulting interviews produced 5 subordinate themes which encapsulated core aspects of the data set as a whole, primarily through addressing the concept of one's 'role'. These interviews indicated that the participants' 'role' encompassed several different aspects, which, whilst interlinking, could be separated out into the themes of 'Work', 'Task', 'Position', 'Duty' and 'Lived experience'. Each of these subordinate themes had a corresponding set of sub themes, as outlined below.

4.3.1 Theme A – Work

‘Work’ is used here to denote the clinical activity of the child psychotherapists interviewed within this research. This contains descriptions of the type of work that is taking place, the duration of the work, or model used within clinics, where it is taking place and other descriptive features of the work.



4.3.1.1 Breadth of work

Participant interviewed engaged in a broad range of work across a range of locations

All the services worked in by participants offered a form of short-term psychoanalytic treatment to parents and infants or children up to 5 years old. 4 out of 7 participants described offering group work to parents and infants, some of which was manualised and ‘evidence based’, whilst others had adapted and created their own schemes of group work. Long term work (exceeding 9 months) with parents and infants was rarely offered by those participating in this study, though some participants did hold a limited number for cases for longer than 9 months. Outside of cases seen by trainees within the service, it was uncommon for children or infants to been seen individually, however most interviewees held some cases where parents alone attended the sessions.

Though some work took place within the clinic, the majority described was outreach and applied work, taking place in health care centres, GP practices, nurseries, children’s centres, local authority venues and within patients’ homes. Referrals came from a broad

range of professionals in contact with children under 5 years old. Collectively, interviewees described that the majority of referrals came through Health Visiting and Midwifery, with only some from GPs, professionals working within children's centres or family hubs, from social care and adult perinatal services and as self-referrals. On occasion, referrals came from hospitals, adult mental health services or as part of a discharge plan from inpatient mother and baby units. The route of referral appeared dictated by either the availability or lack of availability of other services in the local area as well as parameters around the offer that each service (in which participants worked) was able to make, for example some services would not take referrals from social care, whereas other services could only take 'complex' referrals where other professionals were already engaged in the case.

All those interviewed engaged in supervision, consultation and coworking with other professionals in the under 5 network. Some participants were involved in the designed and delivery of infant mental health trainings, work discussion groups or multi-agency case discussion groups for professionals engaged in frontline work with under 5's and families.

4.3.1.2 Fixed and flexible ways of working.

Participants often described engaging in different types of work, ranging from brief interventions with a 'fixed' number of sessions or manualised evidenced based models of working, to work that allowed some flexibility in the approach, duration, frequency, and location of work. In flexible work, the frame of the work could be adapted based on clinical judgement. A recognition of the necessity for both approaches was reflected by participants.

Data from interviews suggested that where cases were complex, flexibility in approach and duration of work was particularly important. All participants commented on the complexities of starting a new piece of work with parents or families, even when there has been consent for a referral to be made. Despite clear need, engagement in work was cited as a significant barrier to effective work taking place and participants noted that that it could take a considerable amount of time and effort to support families in being 'ready' for work to take place. One participant noted that with families who have received historic input from social care or related services there could exist "*often very*

complex difficulties in relation to seeking help or being monitored in some way by services", going on to describe that it could "*take a very long time to get the point that a parent is able to feel trusting and relaxed enough, safe enough".* Another participant observed that*, "There is a tremendous amount of shame attached to having difficulty in the 'attachment relationship', if you like, or the relationship with the baby, so very often we are receiving referrals of parents who are not necessarily available to help. That is to say that there may be some difficulty in engaging them in the help or that they may be reluctant to receive help, not feel that they deserve help or not feeling that they will be able to make the use of help. So that the engagement phase of working with babies and parents is critical, and that critical element of the work does represent one of the main obstacles of helping babies and parents".*

Observations such as those above were used in support of the need for a flexible approach to working with some families. It was recognised that especially where parental or family difficulties were chronic and mistrust in professionals high, there was a need to have the time, space, and the flexibility to 'work cases up' to a point that they were able to engage in work. These families were often complex, vulnerable and the work did not neatly fit into fixed models of individual or group work. Commenting on the effort needed to engage families, one participant recalled that, *"There have been times when I had been trying to engage parents and I'm talking through a closed door, actually talking through a closed door and they will not open the door. And sometimes, over time, it will prove possible for that parent to open the door and at other times the door actually remains closed and that becomes a barrier, a literal barrier, to the work.".* Another described trying unsuccessfully to engage families in work, suggesting that in some cases, families could be, "*too defended and too anxious to engage… and it's persecuting, you have to be in a certain frame of mind to engage."*

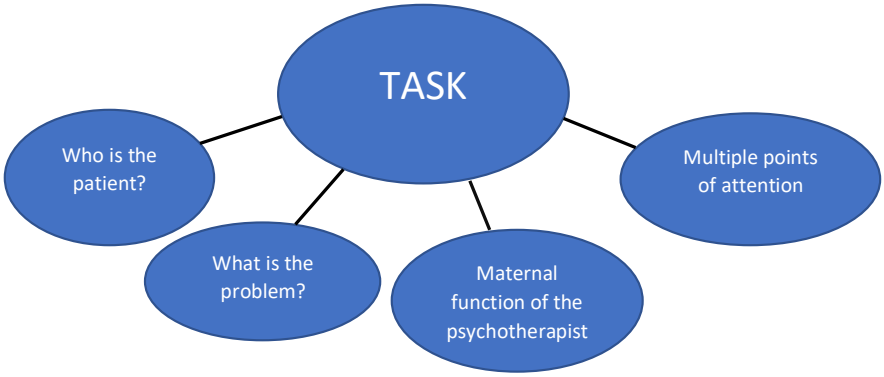
Flexibility in approach to the work extended to working alongside other professionals such as health visitors, children's centre workers or social workers who may have a preestablished relationship and involvement with the family. One participant described this as an *"important and fruitful aspect of their role"* when working with families and was "*necessary in some cases to engage families in support".*

The freedom to use of one's clinical judgment in determining the duration, frequency and approach to a case appeared to be a point of consideration in all interviews.

However, some participants in this study addressed the tension that existed between the freedom make adaptations and decisions based on clinical judgement and the drive to formalise work into fixed, brief models of working, or to adopt manualised and evidence-based models. The drive to engage in such work appeared related to funding and systemic pressures, with one participant noting that one of the biggest challenges of the role was to *"fit direct work into organisational systems where it doesn't easily fit"*. However, attitudes of the clinicians interviewed varied between participants, with some feeling more restricted in their ability to use clinical judgement in their approach to work than others.

4.3.2 Theme B- Task

'Task' contains an examination of the approach used by child psychotherapists when working directly with children under 5 and their families.



4.3.2.1 What is the problem?

All participants described a broad range of 'problems' they encountered within their work. These ranged from more common or *"run of the mill"* problems such as difficulties with feeding, toileting, sleeping, and *"behavioural problems in the form of aggressive outbursts, emotional outbursts or meltdowns"*, to more entrenched relational

or attachment issues resulting from abuse, neglect, trauma, early loss, separation, parental mental health and learning difficulties, or family disfunction, transgenerational trauma and domestic violence.

Understanding and grappling with the question of "what is the problem?" was a complex but central aspect of a child psychotherapist's role when working with young children and their families. Interview data suggested that this 'grappling' began from point of referral and the open exploration of this question continued as a central aspect of the clinical work. Addressing and exploring this question in any given case came with numerous challenges described by participants in their interviews.
Many participants noted the difficulties that referrers could have in articulating or describing their concerns in relation to the children or families they were referring. One participant described being referred, "c*hildren who seem very unhappy or shutdown or screaming a lot for attention or who won't listen, don't sit still… where people are aware of some distress that is hard to articulate".* Another described commonly receiving referrals for young children of mothers with or suspected to have mental health difficulties*, "Where there is a concern about the care they are getting but referrers not really understanding quite what they are looking for.*" A further participant summarised that, *"The presenting symptoms of children can be quite varied, but I think what it is, is that people don't tend to know how to assess that. But what there is some understanding somewhere of, is that people know something isn't quite right, even if they can't really articulate what it is".*

Where problems were identified by parents or referrers, participants reported a tendency for referrals to focus on symptoms, with one participant commenting, *"so much of under 5's 'presentation' is about what they are actually doing, like hitting, biting, not sleeping, crying. And [referrers and parents] want it to be about something quite physical when often it's a manifestation of something unconscious that we haven't quite got to.".*

Participants interviewed demonstrated an interested in understanding the meaning and communication 'underneath' these the presenting symptoms and this was a focus of much of their exploration in the clinical work with families. Participants noted that their interest in looking for meaning and exploring 'what might lie beneath' was not always well met by parents, and the task of providing psychotherapy to children under 5 and

families often included unpicking ridged narratives that may be held by families in relation to the aetiology of a child's behaviour. Most commonly, participants described encountering parents who came to the clinic wanting a quick solution or a diagnosis, typically for ASD or ADHD, and could struggle to engage in a more open-ended exploration of the child's and the family's difficulties. Illustrating this, one participant stated, *"I've had an experience of parents really not wanting to hear perhaps something that we see as being important which… was not being spoken about"*.

4.3.2.2 Who is the patient?

The descriptions of clinical work in the interviews showed a general trend for young children and parents to be seen together. In rare circumstances, individual work might be offered to children who present with entrenched difficulties and need a space in their own right. It was not uncommon for parents to be seen alone.
Interviewees demonstrated that grappling with the 'location of the problem' was a central part of the task of working with small children and their families. This task included considerable attempts to unpick the muddle and to address narratives, often concretely held by parents and at times referrers alike. One child psychotherapist described it as such; **"***What they'll be reporting is the experience… experiencing difficulty in parenting their child or some aspect of the relationship. Though often in the referral or initial meeting this is rarely identified as a difficulty in the relationship, it's all located in the child so there can be quite a lot of unpicking."*

Though case studies were not explicitly asked for in the interviews, many interviewees described the regular complexities of working in cases where transgenerational trauma and or adult mental health was a factor in the work, but whereby there was a tendency for difficulties to be located in the child. Many participants discussed the role that unconscious projections and projective identification could play in 'problems' becoming located in the child solely. One participant described that, *"the strength and force of the projections that go with the parents into their child… [is] quite a challenging aspect of the work, particularly with work under 5's. Quite a lot of the pathologizing from parents into their children about what's wrong with my child, quite often wanting a diagnosis"*. Interviewees often considered the importance of using their capacity to tune into the transference and countertransference within sessions as a tool

in deciphering the unconscious transmission of a 'problem' from parent to child, or between parent and child.

The majority of the participants showed a preference for viewing the difficulties as neither located in the child or the parent but as located in the relationship between child and caregiver, and sought to treat the relationship as the 'patient'. Describing the challenges and confusions of engaging in under 5 work, one participant commented, *"It can be confusing who your patient is. Are you working with the parent or the carer? Are they your patient or is the child your patient? That can be quite difficult and confusing in under-fives work. You are having to balance two aspects of the work and essentially, like I said, your patient is the relationship between the two. So, it's almost as if you're juggling three things; the parent, the baby and the parent-baby relationship"*

Whilst participants indicated a level of satisfaction with approaching the work from a 'relationship as patient' perspective, some voiced concerns about structures within health care services that sought to somewhat artificially separate parents and infants in terms of service allocation and registered patient with whom the work is taking place.

4.3.2.3 Multiple points of attention

Keeping one's attention on many different dimensions of the work at once emerged as another core aspect of the 'task' of working with under 5's and their families and was touched upon in all interviews. Participants described how they approached their work with the parents and infants assigned to them and the sources of data that they might use to come to an understanding and formulation of their cases. Child psychotherapists interviewed described attending closely to the relationship between the parent(s) and infant in the here and now, attending to the dynamics in the room, including behaviour, interactions, and points of attunement and misattunement. Participants would also use their own capacity to tune into the emotional state of the mother, father or infant, using their sense of the transference and countertransference in the room as a tool to inform this.

With attention being paid to the micro, came also an appreciation for the macro, where participants also considered the importance of attending not just to the present but to

the past as well. One participant described, *"But it is also about helping parents think about their experiences of being children and how they were parented. So, I think the real value of being a child psychotherapist is that we often think across time zones, so we can think about the past and the present. And we can hold these multiple time frames, and if we can help parents think that through, it can be that that can release the child from those negative projections that are going on."*

Others described an attention to the 'here and now' that would incorporate a curiosity about aspects of the past such as the parent's individual and combined history, aspects of the conception and birth of the infant as well as parents' feelings and ideas about their baby. In describing a piece of work recently undertaken, one participant recalled; *"We were working on the floor with mother and treating baby as a separate person with a mind. He was a participant in therapy. And we were thinking in both the 'here and now', about mother's feelings and concepts and ideas about her baby, and also looking at the baby as a thinking, feeling person who is acting and responding and developing a conversation and a dialogue and discourse with the mother about that… Looking for examples of phenomena in the 'here and now' such as the baby's gaze points, what the mother might feel about that and what the mother might see when she looks at her baby. Then secondly thinking about her history and how that applies"*

In addition, all participants indicated that holding 'risk' in mind was another dimension to the work, with many noting the complexity of managing this task alongside the clinical work.

4.3.2.4 'Maternal function' of the psychotherapist.

Theoretical concepts relating to the function of the mother within the mother infant dyad, such as Bions concept of 'container – contained' as well as Winnicott 'holding' were frequently mentioned as central aspects of the 'task' of undertaking clinical work with mothers, infants, and young children. Participants were unanimous in their view that an aspect of the clinical work was to contain the anxieties of the parents and children seen clinically. One participant commented, *"I've seen it first-hand, if you*

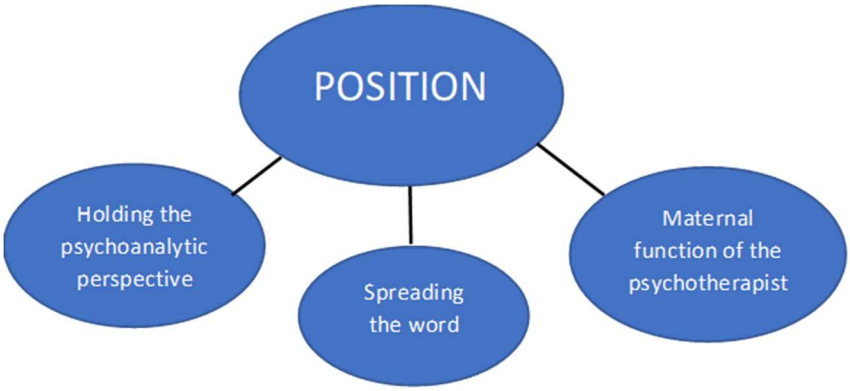
could contain something on behalf of the parent, you can really get on with containing something on behalf of the infant."

Beyond that of containment and holding, psychotherapists interviewed frequently indicated the providing maternal functions such as sorting out the muddle and tolerating negative projections from patients also form a core part of the clinical work. One participant commented, *"You are encountering really strong projections, ironically as a child psychotherapist not from the child but mainly from the parent or carer so that's the challenge of the work"*.

Within the subordinate theme of 'task', there was relatively little disparity between participants. Whilst the features of the clinical work could vary greatly in terms of location and duration of work, the task performed within this clinical work and the way in which the clinical work was approached was concordant between participants interviewed.

4.3.3 Theme C- Position

'Position' describes interviewee's perceptions of the place that they, as a child psychotherapists hold in their clinic and the under 5 networks around them.



4.3.3.1 Holding the psychoanalytic perspective.

Interviews indicated that holding and representing the psychoanalytic perspective within their teams and within the network appeared to be considered a fundamental aspect of the role of the child psychotherapist. This could involve providing psychoanalytic consultation and supervision to team members and professional in the extended network as well as more informal contact and conversations with other professionals, as well as attendance to 'Child Protection', 'Child in need' or 'Professionals' meetings in which child psychotherapists might provide psychoanalytically informed insight or views.

Data from the interviews indicated that the sharing of psychoanalytical insight and thinking could be met in several different ways. Participants described times where the sharing the psychoanalytic lens with colleagues had been supportive and well received, with one participant commenting, *"one of the biggest challenges is to be able to articulate the work to non-psychotherapist and the value of it, but I think when people get it, the wonderful thing is that they can be really delighted and can really see some things that they had been unable to see. So, I think that if you can really help people to see it, it is hugely helpful".* Another participant shared a similar reflection; *"So I think if you also have a professional who you can help to see what you are seeing it can be enormously illuminating and people can be really surprised and amazed at how much infants can communicate about their experience… other professionals find this age group so difficult to understand, think about and work with that actually it can be delightful to see how they can blossom in their understanding and way of working"*

Challenges in holding and sharing psychoanalytic perspective with professionals were well documented in the interviews. These included a sense that thinking 'in this way' could stir up anxiety in others and could be met with resistance, hostility or suspicion, even when consultation has been actively requested. One participant commented, *"I think there is a lot of misconception about what we do and a lot of anxiety, if you mention the word attachment or relationship people can get quite worried about it".* When describing an exchange between themselves and a professional, another

participant commented on the personal difficulties or resistance that some professionals might have in relation to wanting to engage in thinking about meaning and relationships, commenting, *"for her there was something about the focus on emotional experience that was just really difficult. I think it can stir up so much about peoples own experiences, their own attachments, maybe their own attachments with their own parents"*.

4.3.3.2 'Spreading the word'

Data indicated that an aspect of the role that child psychotherapists working with under 5's perceived that they played was to 'spread the word' about infant mental health and the importance of relationships in infancy. This reflected a sense that appropriate knowledge sharing and providing insight was something that child psychotherapists sought to do in their interactions within their teams and with professionals in the network. Many participants noted the inherent difficulties in translating and communicating psychoanalytic concepts and ideas around infancy to professionals unfamiliar with them. A common theme in relation to this was simply the amount of time it could take to begin to embed these ideas into teams or the wider networker. One participant commented*, "It has taken time to develop understanding in my colleagues within my own team - my CAMHS colleagues and also social workers, to really being able to focus on the child's experience and prioritising that particularly when they were concerned around the child's experience relating to risk."*

Many of those interviewed emphasised the need to be patient and present with colleagues and professionals, and to allow interest and take up of the psychoanalytic viewpoint to occur slowly and gradually. One participant described their experience within their team, *"I am working in a multi-agency team here so my family support worker colleagues will approach me informally. Sometimes we will have a conversation which starts extremely informally about families that they are working with or with referrals that have coming in or an experience they have had meeting with a family or meeting with a child or hearing about a child from whoever has referred to family support. So, we might start with a very informal conversation then often they develop beyond that".* Another participant made reference to the importance of "*being present in team meetings and available to support*" continuing that, "*sometimes it's a difficult*

case and I will offer my support, I'll ask whether they would find it useful to have some space to think about a case, and sometimes it's taken up and sometimes it isn't." A further participant reflected on their interactions with professionals in the extended network, noting that, *"it's difficult… (laugh)… You have to sell yourself a bit, you know?"*

Most participants indicated that they, along with the services to which they belonged were putting effort into education programs, CPD courses and work discussion groups in an effort to educate the network about the mental health needs within infancy and over half the participants interviewed were engaged in this type of work. Voluntary multi-agency profession discussion groups had been set up by some participants, with two participants indicating that this was a shifting focus within their work.

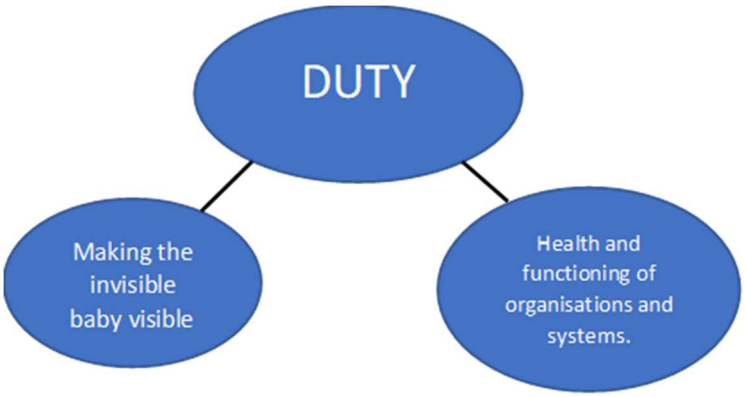
4.3.3.3 Maternal function of the psychotherapist

Participants were unanimous in their observations that anxiety could and did permeate many teams working in the under 5 network. This was understood to be a combination of extreme pressures on under 5 services, particularly following aggressive cuts and reduction in services in some regions (as reported by participants) and as a result of very little time to think and to 'catch one's breath' in the work. The data indicated that participants viewed that within supervision and consultations (both formal or informal) child psychotherapists could play a valuable role in supporting in the containment and processing of anxiety, often utilising the same skill set as used in clinical work with children and families. In this way, participants described the role that supervision could play, not only in supporting the development of understanding in other professionals, but in supporting professionals to manage the emotional demands of frontline work. One participant reflected, *"And when you are talking to other workers, they say that it is just so nice to be able to talk to someone about this… to be able to talk to you, to have someone to share their thoughts and experiences, even if it's containment not just understanding."* Another commented that*, "the level of anxiety around the perinatal period is really intense… I often receive referrals in a state of panic and I think it can be helpful to offer a consultation to slow things down and to help professionals feel more contained so that they don't need to rush into something"*

Within the subordinate theme of 'position' there was considerable variance in the experience described by participants. Some participants conveyed a general sense that they felt well integrated and valued within their teams and within the professional networks around them. These participants tended to describe experiences where the psychoanalytic viewpoint was well received and some professionals in the network made use of consultations and a space to think. Other participants described vastly different or mixed experiences, where supervision, consultation or sharing of insight or knowledge was not well received, received with hostility, or seemed too at odds with the working practices of other professionals to be of use. High staff turnover within the network and services and services at the brink of becoming 'overwhelmed' was cited as factor which influenced the uptake of support.

4.3.4 Theme D – Duty

'Duty' is used to indicate a wider sense of moral obligation felt in relation to the work taking place with children under five, their families and the networks around them.



4.3.4.1 Making the invisible baby visible.

Participants conveyed a strong sense of duty within their work to 'give the baby a voice' and to advocate or communicate on behalf of the baby or young child. This sense of duty was expressed in relation to direct clinical work, in work within teams, in work within the professional network, and in work undertaken at a policy,

commissioning or governmental level that was engaged in by some of the more experienced participants.

In relation to clinical work, one participant commented, *"The most valuable thing to give an infant, particularly nonverbal infant, is a voice. By talking to what the child is showing you and making links with what mums and parents are talking about, one can articulate and elaborate an infant's experience to the parent and that may be very different from what the parent's experience is… or what they feel is happening… [one can] try to disentangle difficulties and try to explore them and to make links".* Another participant expressed that an aspect of their role was to *"[be] there to take a bit of a stand for children under 5… to hold a position, to have a voice. To be that voice. It's really valuable."*

Reflecting on the challenges of drawing attention to and holding onto the emotional and relational experiences of young children, one participant commented that, *"when babies are little it's much harder to see that there is a difficulty. It's much harder to see that actually this baby is not sleeping because there is a difficulty in the relationship or there is a difficulty somewhere. A lot gets written off."*

The notion that the baby or young child's experience could often get 'written off' or overlooked ran strong within the data set. One participant reflected on why this phenomenon might occur, suggesting that, *"infancy is the furthest away any professional is… As an adult you have words, you would have psychological structures, but an infant's experience is not readily accessible…. no one can really understand what it's like to have no words and no experience of the external world so [professionals] are as far away as they could get, as indeed every adult is. But I do think it makes particularly difficult to try to get them to put themselves back in the infant's shoes, if you like".* Another reflected that, "*there is this kind of idea that children grow out of things or don't notice things when they see them, or that it doesn't mean anything… this other idea that children from an extremely young age have the capacity to relate and to understand, I think can get a bit lost, can get overlooked and the trajectory gets lost"*

One participant described their sense of frustration in relation to the treatment of children under 5 at a policy level, stating that commissioner and policy makers *"pay lip service to the idea of early intervention but there's nothing really clear there. And there*

is absolutely nothing specified in terms of funding!... There just isn't any funding that dedicated to that. I think 44 of the local clinical groups have admitted that they were funded to provide a 0 to 18 service and do not provide anything for under-fives". This participant went on to describe the active role that they had played to challenging this. Two other participants interviewed also played active roles in campaigning at local government level.

In relation to this same theme, a further participant described *"It's a vicious circle. CAMHS is so under pressure to see adolescents that they can't make space for under 5's. And if clinics also lack the confidence to work with under 5's then they are not going to have the capacity to make that space for under 5's. So that's a challenge for the training. To prepare us to take up that position and to hold that voice."*

4.3.4.2 Health and functioning of organisations and systems.

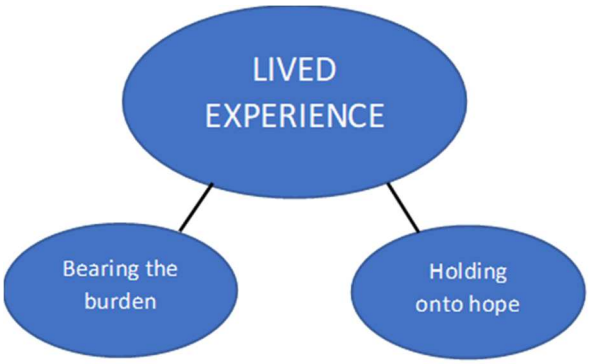
Many participants reported passionately on their concerns about the state of other local authority services tasked with providing support to children under 5 and their families. Concerns raised included the observation of underfunding or cuts to local provision, which could lead to burn out and high staff turnover. Many participants voiced concerns in relation to the treatment of frontline staff working to support children under 5. Within this seemed to be a trend to view difficulties within the network as symptoms of the larger problem of the demands put on frontline workers who were often viewed as poorly supported and overwhelmed. One participant commented, *"Midwifery is vastly under supported, and I think extremely stressed and quite traumatised by what happens to them as professionals and there is a striking lack of support for them. I am someone who is very concerned about frontline professionals becoming not only burnt out but sort of immune to the level of distress and trauma that they encounter every day and I think they need considerable support and supervision for that…. I think there is something about trying to support and protect frontline workers so they can maintain consistency and stay in their jobs"* Another participant commented that, *"professionals are massively stretched and hugely preoccupied by other things, completely overwhelmed and not very well looked after".* A further participant observed that

"systems… are so unsupportive that all the workers can do in some settings is to shut down".

A further participant expanded on the impact that difficulties in the wider network could have on effective delivery of support within their services, commenting, *"There is a real sense of burnout and rather than organisations attempted to support staff the staff manage, the authorities are stretched and staff manage this by shutting down so that they are able not to make too much contact with patients and clients, so avoiding the anxiety… they cannot think that actually the service [worked in by the participant] might be useful so actually our service just feels like an additional burden to all the other tick boxes and checklists that they're under. So, I think it's a much more defended and defensive mental position that each individual takes up in relation to the organisational structures".*

All participants observed some level of structural difficulties in the network or system which impacted their role and acted as a barrier to successful early identification of difficulties in small children. However, the degree in which participants engaged with this issue as an active part of their role varied between those interviewed. As part of their wider role, two participants were actively engaged in trying to bring about system change within the area that they worked, and a further 2 were engaged in offering supportive supervision groups to staff within the wider network of professionals. However, one interviewee described the tension in trying to bring about change commenting that, *"as resources are so stretched, it can be a bit fraught between services and within the network. Things can become quite territorial".*

4.3.4 *Theme E- Lived experience*



All interviews indicated that working as a child psychotherapist with children under 5, their families and in the context of their teams and the wider professional network was an emotionally demanding endeavour. Language used withing the interviews expressed a broad emotional response to the work including frustrations, hope, anxieties, concerns, feelings of being overwhelmed, and moments of joy. The nature of the work was described as both emotionally moving and emotionally stirring. There was some variance between participants in terms of experiences within their role, with some expressing greater levels of optimism and contentment with the role and some feeling greater pressure and greater levels of frustration. Managing the emotional tole inherent to the work appeared to be implicitly or explicitly described by participants as an aspect of the role.

4.3.5.1 – Bearing the burden.

Communicated throughout the data set was the emotional tole and impact that this work could have on participants engaging in it. Those working as the sole psychotherapist in their team describe aspects of the work as 'lonely', whilst others described struggling within hostile and defensive systems where thinking was not always welcomed or encouraged. Participants also described the weighty emotional impact of working with complex cases or significantly unwell client groups, with one participant commenting on the difficulties of "*managing multiple risks in… team[s that are] not set up to manage multiple risks from adults. This is also part of the work, but it can be hard to*

find the right services support and manage and hold some of those risks". Participants described being left feeling, *"panicked"*, as if they were *"swimming against the tide"* or often as if they were, *"walking a tightrope"*.

Two of the 7 participants commented on the impact that this type of work could have on their personal life, with one commenting, *"I know as a parent this work can be painful for me, it leads me to reflect on my own attachment with my own children, the mistakes I feel I have made and the things that went wrong"* Another described *"I have two children myself and I can understand those primitive anxieties around this period – it's a time of high drama, high stakes and highly testing for the parents and professionals"*.

Implicit within the data set as a whole, but to different degrees within individual interviews was the sense of being overstretched and overloaded with the task of managing the emotional impact of the work, of navigating the network, and of managing the conflicting demands of the role. Many interviews gave the impression of participants being regularly 'on the go' and managing the additional task of moving between family, outreach locations and different sets of professionals. Noted too within the interviews was the difficulties of holding onto one's own sense of competence when feeling under fire, or else in meeting the expectations from professionals and families when placed as the 'expert'. Participants also described the emotional tole of remaining in touch with the high levels of primitive anxieties in infants, young children, families and in professional networks alike.

4.3.5.2 - Holding onto hope.

All participants also expressed some level of interest, enjoyment, and hopefulness in relation to the work they were undertaking. One participant expressed hopefulness in relation to having the opportunity to work therapeutically with very young children, commenting, "*it's the age group where you can really make things happen in the sense that things aren't fixed, so just as mothers can become seriously unwell with post birth postpartum psychosis for example, they can also recover very easily and also babies and mothers way of relating is not fixed and can be very malleable and can move very*

quickly. In terms of cost efficiency, it's absolutely the best time you can put services in and it can be the most rewarding time because more than in any other period, it can affect the trajectory developmentally or psychologically quite quickly. It can be very rewarding time to work from a professional point of view" Another participant reflected positively on the usefulness of the skill set they felt they had as child psychotherapists, commenting, *"Child psychotherapists not only have a role in supporting needs of children under 5 but they are extremely well placed to do that work successfully and to be affective because of the nature of and thoroughness of their training."*

5. *Discussion and conclusions*

5.1 Summary of Overall themes

The five subordinate themes of 'work', 'task', 'position', 'duty' and 'lived experience' captured aspects of the 'role' that child psychotherapists perceived that they played when working with under 5's, their families, within their teams and within the professional networks around them. 'Work' and subthemes of this category captured concrete features of the work undertaken by child psychotherapists, including descriptions relating to the nature of the work being carried out and location and duration of work. 'Task' and it's subthemes captured details relating to the clinical work with families undertaken by child psychotherapist, focusing on the way in which participants approached and thought about their clinical work. Within the subordinate theme 'Task', a greater sense of homogeny was present between participants. The subordinate theme 'Position' and related subthemes captured aspects of the participants role relating to working within their teams and as part of a wider professional network tasked with supporting the needs of children under 5. Within the subordinate theme 'position' clearer divergence in experiences and attitudes amongst interviewees was present. 'Duty' and related subthemes captured an expressed sense of moral standing and ethical leaning expressed by interviewees. Lastly, 'Lived experience' and related subthemes sought to capture aspects of the impact of the role on participants.

Whilst themes have been presented in discrete categories or clusters, many themes were intrinsically and complexly interlinked or interwoven, with the subthemes 'maternal function of the psychotherapist' expressing itself in both the clinical 'task' and the 'position' of a child Psychotherapist in the network. Taken together, the themes capture the complexities of the role that child psychotherapists view themselves as holding in relation to supporting children under 5.

5.2 Discussion of individual themes

5.2.1 Theme A- Work

A question arising from the theme 'work' is whether child psychotherapists interviewed are working in similar ways to other participants or to child psychotherapists previously working in this specialism. Despite the differences in the services to which they belonged, the interviews indicated there were clear areas of overlap and similarity in the activity of participating child psychotherapists currently providing support to children under 5. All participants described a broad range of clinical activity undertaken within their work. Each interviewee described working clinically with individual families, providing formal and informal consultation to colleagues and other professionals in the surrounding network and playing a role within these networks. Collectively, the clinical work with patients took place in a host of locations that would generally be considered 'outreach' including patients' homes, children's centres, in general practices, with each interviewee engaging in some outreach work.

When considering the most common model of intervention, all those interviewed described working on a 'small-batch-of-sessions-followed-by-a-review' model, where sometimes, following this review, another batch of sessions might be offered if deemed necessary. Most commonly, young children were seen with their parent/s or carers. Whilst the number of sessions in a 'batch' could vary between services, this way of working corresponded closely to the model of brief intervention with under 5's outlined by Bradley and Emanuel (2008) in *"What can the matter be?" Therapeutic Interventions with Parents, Infants and Young Children*. However, psychotherapists interviewed did not appeared to be replicating this exact model of working but rather

appeared to be following a ‘tradition’ of psychoanalytic work with children under 5’s, which had undergone small adaptations based on the parameters of the service to which they belonged.

Despite an overall similarity, there were some areas of discrepancy between the practices of participants and between child psychotherapists past and present. Over half of the participants described running group work with parents and infants, an area not well documented in previous literature relating to under 5 work undertaken by child psychotherapists. Another area of shift in the working practices of Child psychotherapists past and present appeared to be in the location that the clinical work took place in. Although no quantitative data was collected within this research to corroborate this, participants generally described regularly engaging in ‘outreach’ clinical activity where participating child psychotherapists would travel to work in locations that were more convenient for the patient / family, including local children’s centres, GP practices, nurseries and sometimes within the patient’s homes. Whilst examples of outreach work are outlined in the literature review of this research, descriptions in the literature of child psychotherapists conducting outreach work appeared less common than descriptions of ‘in clinic’ work. This might suggest that there is a general shift away from working in the consulting room and towards outreach work when working with under 5’s as well as a trend in the direction of the incorporation of facilitating group work as part role of child psychotherapists working in under 5’s service.

It is not possible from the data set to fully account for these shifts in working practices and further research would be needed to explore this. However, interviews do indicate that a drive to provide easy to access, cost effective interventions may well contribute to this shift in working practices and thus might be driven not by a natural growth and evolution in the working practice of child psychotherapists but by external factors such as budget, service design and commissioning requirements.

Whilst participants did describe the use and effectiveness of brief models of intervention for some families, participants also indicated that they often experienced working with families that did not fit neatly into brief models of intervention and that a lot of additional input, time and flexibility was needed to engage a family in an intervention. This suggested that’ at times, the reality of the role that child

psychotherapists played in direct work might differed quite significantly from the role as defined 'from the outside', through service design, and was considerably more messy than might be readily understood by commissioners or those driving designing services. Despite descriptions of complex cases regularly being held by participants, there was an absence of long-term work being carried out with under 5's and families by those interviewed. This description of working practice conflicts with Barrow's (2008) concern that effective brief intervention is dependent on having clients "*who can make good use of a brief intervention*" and that it may not be suitable for the "*very deprived, high-risk, multi-problem population."* (p70).

In line with this, data collected within this study indicated that there were areas of tension in defining and understanding the role of a child psychotherapist when working with children under 5 at quite a fundamental level. As one participant commented, a challenge of the work was *"to fit direct work into organisational systems where it doesn't easily fit*", and this sentiment was echoed by other participants. This represented a complex aspect of the work, where some participants appeared to feel frustratedly bound within organisations or systems which did not readily allow for psychotherapy to take place, or where the psychoanalytic view and method of working was not wholly compatible with the system within which it was trying to exist. Briggs describes and explores a similar tension in his paper *Containment lost: the challenge to child psychotherapists posed by modern CAMHS* (2018) describing the potential risk of work becoming 'meaningless' and clinicians feeling 'powerless' in effecting service design.

The tension that could exist between 'formalising' work into fixed models of working and the clear need in some cases for greater flexibility in working at the clinician's discretion, based on clinical judgement was illustrated within the data set. It brings to mind Winnicott's (1960) notion that the needs of a baby must be met by a mother, not in a mechanical way, but in an attuned an empathic way in order for psychological development to ensue. Whist formalisation of work might be deemed necessary, one might consider that at times, the drive to formalise work might fall more closely in line with a 'mechanical' response to need and may fail provide families with the attuned and responsive support necessary for growth and development. Concerns around the structuring and target driven culture of services within the NHS has been noted by other

academic observers, with Proctor, Wallbank, & Dhaliwal, 2013) commenting that, "although objective measures can be helpful, they provide no more guarantee of good treatment than the clinician's opinion. Our preoccupation with measuring everything can become a defensive distraction from the task of caring for the patient" and Evans (2014) concern that, "targets have undermined clinical judgment."

5.2.2 Theme B- Task

A sense of homogeny between participants was present within the theme of 'task'. Despite the concrete features of the work, such as location, duration and family members included in the work varying between participant, or even between cases held by the same participant, descriptions of the clinical 'task' remained similar. This indicated that despite the 'shape' that the clinical work took, child psychotherapists interviewed adhered quite loyally to a shared set of psychoanalytic principles, with a shared 'way of seeing' running strongly through the data set. Participants commonly referenced concepts of core psychoanalytic theorists such as Klein, Bion and Winnicott describing 'projections', 'infantile anxiety', 'containment', 'the unconscious' and the notion of infants and their caregivers being psychologically bound up with each other, suggesting a strongly shared theoretical underpinning to the work carried out by child psychotherapists and even a sense of a professional identity related to the subscription to this shared set of theoretical principals and beliefs.

The title of Bradley and Emanual's (2008) "*What can the matter be?" Therapeutic interventions with parents, infants and young children* and papers comprising this book, set out that a central task within brief work with under 5's is to address the question of 'what is the matter?', and literature within this book supports the idea that a central aim in brief psychoanalytic work with young children and their families is to grapple with this question and to expand understanding around nature of the 'problem' rather than to provide solutions. Data from interviews suggested that within their clinical work, participants continued to engage in grappling with this fundamental question, reflected in the subthemes 'what is the problem?' and 'who is the patient?'.

Participants described working with young children with a broad range of presenting problems, from somatic to behavioural difficulties and withdrawal to distress. The

presenting problems outlined by participants strongly aligned with the vast range of presenting issues documented by child psychotherapists and discussed within the 'literature review' of this research. However, more weight was given in the interviews to addressing and exploring the difficulties that could occur at point of referral than can be found in the literature on the subject. All participants made reference to issues surrounding incoming referrals and the majority indicated that it could be a point of considerable difficulties within the work. Some participants presented a seemingly paradoxical situation of working within a community where there was a recognised need for early intervention but where appropriate referrals to the services were sparse. Obtaining appropriate referral relied quite heavily on the existence of a number of skills or characteristics in the referring group (GP's midwives, health visitors, nursery staff etc) described by participants, which included referrers having an adequate understanding of infant mental health, being able to 'spot' subtle signs of infants or young children in distress, feeling confident in articulating concerns in referrals, subscribing to the idea that good mental health mattered in infancy and that young children could be effected by adverse circumstances, having a good relationship with service that they were referring to and having the time to make a referral. Together these indicated that 'need' within a family or child would not always lead to referrals being made and that often the presence of knowledge, personal subscription to beliefs, relationships and time impacted on referrals to child psychotherapists for early intervention. This point of difficulty is important to highlight as it influences and impacts the role that child psychotherapists play and will be discussed as greater length within the theme 'position'.

A further consideration in relation to the muddle that could present at point of referral is that this may well be an expression of the muddle that some families are in at point of referral, which then pervades outwards into the network. In this way, referrals made with a great deal of panic, where there is an expressed need for immediate action, might relate to an unconscious transmission of anxiety from family to referrer which is unable to be tolerated and thus is passed rapidly and in a rather unprocessed way to child psychotherapists and the services in which they work. In a similar fashion, 'splitting' which might exist within a family's functioning, can reverberate into the network causing vastly different opinions between professionals and making linking up with professionals more difficult. This same concept might also partially explain or relate to

the lack of referrals noted by some participants working in areas where need for early intervention was clearly high. One could speculate that in some of these instances, neglect or denial of need taking place within some families could find expression in the professionals in contact with the family, who then may neglect their duty of care or join the family in a denial of difficulties.

The phenomena of transmission of individual or family pathology to the professionals working with such patients has been described by numerous psychoanalytic authors. On detailing such an occurrence between members of a family and professionals, Britton (1981) reflects that, *"we seem to be dealing with repetitious actions which transfer a pattern of relationships from one situation to another in which new participants become the vehicles for the reiterated expression of the underlying dynamic"* (p.49). Here, Britton suggests that professionals engaging in with certainly families may find themselves drawn into and acting out certain set roles within the family's dynamic. Referencing Britton considerations on this subject, Emanual (2002) details similar observations in her work supporting social workers with looked - after children, describing, *"'the profoundly disturbing primitive mechanisms and defences against anxiety' used by and families get 're-enacted' in the system by care professionals, who are the recipients of powerful projections. These defences, including unconscious attacks on linking, can interfere with the professionals' capacity to think clearly or make use of outside help with their overwhelming caseloads."*

Emanual refers to the 'triple deprivation' experienced by some looked after children, detailing the original external trauma, abuse or neglect of the child as the first source of deprivation, the child's internalised experience of trauma, abuse or neglect as the second deprivation, and the 're-enactment' or acting- in to the child's pathology that occurs in professionals and systems as the third source of deprivation. Whilst it is beyond the scope of this research to full explore the dynamics or complexity around the point of referral noted by many participants, it is nonetheless important to highlight that managing complexities around the point of referral comprised a necessary and sometimes time-consuming aspect of the role of child psychotherapists working with under 5's. Due to their extensive training and experiential learning, particularly within the 'infant observation' module, child psychotherapists may be well equipped to identify the unconscious dynamics within families that may draw them or other professionals into re-enactments.

A further aspects of the theme 'task' was the identification of the 'patient' within the clinical work. Bearing Winnicott's (1960) consideration that the *"infant and the maternal care belong to each other and cannot be disentangled"* (p.40) in mind, it is perhaps unsurprising that child psychotherapists participating within this study reflected on the difficulty of separating out maternal and infant mental health, most regularly seeing mothers/ parents together with their infant. This approach comes with its own set of challenges as commonly a child psychotherapist might find themselves balancing conflicting or competing needs of parents and children within their work. Reflecting on this issue when encountered in her work within the 'Tavistock under-fives team', Miller (2008) holds that "*the parent is here on the child's ticket and we must bear in mind the child in the treatment, whose needs may sometimes be experienced as competing with the needy child in the parent."* (p.41)

Some participants showed a preference for regarding the parent-infant relationship as the patient. This echoes Fraigberg's approach of working with parents and babies together and Hopkin's (2008) reflection that *'the infant can be best treated by treating the infant-parent relationship'* (p54). Barrow's (2008) too holds a similar position, asserting that, "*most infant mental health clinicians would agree that the mental health needs of the infant and the parents are so inextricably interlinked that they cannot be addressed separately".* (p76) Whilst clinically this idea appeared to sit comfortably with participants, conflict was noted by some participants in relation to the practicalities of taking up this position in services they worked within, due to tendencies of systems/ services to require a 'named patient' within the work, i.e, the need identify whether the patient was the infant or the mother. For participants that identified themselves as working frequently with 'unwell' mothers, this conflict was particularly pressing. Such mothers may not have previously been identified as unwell, might not identify themselves as unwell, might fall below thresholds for adult mental health services or might be unwilling to access support in their own right. In these instances, a child psychotherapist working with mother and infant, with 'infant' as named patient could find themselves in precarious situations, working with an unwell mother and inadvertently holding the related risk. This dilemma seems reflected in one participant's consideration that one of the biggest challenges was to "*fit the work into systems in which it did not comfortably fit"*.

Within the 'task' of engaging in clinical work, participants also described making use of multiple sources of data in the sessions, reported as the subtheme 'multiple points of attention' and providing a 'maternal function' within the therapy, reported in the subtheme 'maternal function of the psychotherapist'. Both these subthemes tied closely into recognisable aspects of the role of a psychotherapist when working with patients of all ages.

Alongside holding the questions of 'what is the problem?' and 'who is the patient?' in mind, and balancing 'the parent', 'the infant' and 'the parent -infant relationship', collectively participants noted that their clinical interventions involved paying attention to the 'here and now', to the relationship observed within the session, to the parents' perceptions and ideas about their child, to aspects of the parent's past such as their own early childhood and relationship with their parents, to the relationship between parents and to their own countertransference feelings in the session. Descriptions of 'defences', unconscious dynamics and references to theoretical concepts given within the interviews supported the notion that the theoretical framework was also held in mind during clinical work. The implementation of close observational skills like those honed within the 'infant observation' module of the training of child psychotherapist were also evident within the data set. This capacity to hold or move between multiple points of attention strongly reflects Rustin and Emanual's (2010) observation of "*the fluctuating shifts in attention and perspective required when undertaking brief work with young children and their families". (p.83)* Not present within the data set but noted by Rustin and Emanuel (2010) as further points of attention, from which useful information could be intuited which included close attention on the relationship the family made with the therapist and the process of communication amongst family members.

The impression garnered from reading individual interviews was that participants had slightly different styles when approaching this work, with different 'points of attention' seeming to hold greater importance for different participants. However, it was understood that all participants indicated that they held multiple points of attention within their clinical work which functioned as sources of data, informing interpretations made within the clinical work. It is possible too that these multiple points of attention

also functioned as or gave access to, what Stern (1995) terms "ports of entry" to the work, allowing the therapist to find routes into the work with families seen.

Further to holding these points of attention, data from the interviews also indicated that child psychotherapists viewed themselves as playing particular 'functions' within their clinical work, many of which closely aligned to the function that, within psychoanalytic theory, a mother was understood to play with her infant. Most commonly, participants described providing 'containment' by being present to hear, understand and absorb some of the distress of their patients. Playing this function within therapy and its importance in the therapeutic process is well documented within psychoanalytic literature and by many authors in relation to working with young children and their families. On the importance and potentially transformative effect of this providing this function, Hopkins (2008) suggests that *"The family know that their concerns have been heard, that they are not alone with their troubles, that they are not blamed for them, and that there is hope for change. If all goes well the therapist is experienced as a benign parental figure who may be felt to replace a curse from a wicked fairy godmother with a blessing"* (p.66)

A further two functions outlined by participants were the function of 'sorting out the muddle' and 'tolerating negative projections'. Again, these functions bear similarity to maternal functions such as Bion's 'reverie' and 'Alpha function' and Winnicott's understanding of the need for a mother to be able to tolerate both her own and her baby's aggression without acting on it. Both Barrows (2008) and Pozzi (1999) consider the therapeutic benefit of providing a 'thinking function' in their work with young children and their families, suggesting that, "*the function of offering the parent the model of a thinking object… is critical. The fact of worrying away at thinking is, in a sense, the therapeutic agent rather than any answer that this may lead to*." (Barrows, 2008, p.77), and that, "*Containment through mental digestion, transformation (Bion,1962), silent or verbalized interpretations, [takes] place so that insight [is] achieved by the parents and the child"* (Pozzi, 1999, p.70)

5.2.3 Theme C- Position

The theme 'position' was comprised of three sub themes; 'holding the psychoanalytic perspective', 'spreading the word' and 'maternal function of the psychotherapist', all of which captured aspects of how participants understood their role within their teams and within the networks around them. 'Holding the psychoanalytic perspective' entailed representing psychoanalytic ideas and views of cases in discussions with colleagues and other professionals within team or professionals' meetings or within multi-agency case discussions. Several difficulties in doing so were noted by participants which included challenges in translating psychoanalytic ideas and communicating them to colleagues and in bridging the gaps in knowledge and ideas around infant and young child mental health that might exist between child psychotherapists and other professionals working with young children.

Participants detailed providing supervision and consultations to professionals within and outside of their teams. The phrase 'spreading the word' was chosen to denote these experiences as, in addition to the provision of formalised engagement in supervision and consultation with other professionals, it captures the essence of their reported engagement in less 'formal' types of knowledge sharing within other professionals. In addition, 'spreading the word' pays tribute to the 'active' rather than 'passive' approach that participants often seemed to take in relation to the task of knowledge sharing, which involved a reaching out and offering to other professionals. Mixed experiences were reported by participants in relation to knowledge sharing with professionals. Some participants could readily offer up instances in which they perceived that their insight or knowledge had been experienced as 'helpful', observing that professionals could be 'surprised', 'amazed' and 'delighted' when helped to understand something, or by having their felt experience of a family heard and understood. This finding falls in line with Rustin and Emanuel's (2010) consideration that the offering of early years consultation "*can be a highly effective and satisfying exchange of thoughts: it simultaneously enriches the skills of a range of professionals and provides help to their clients*" (p.85) and Emanuel's (2002) reflection that psychoanalytic discussions within casework can "*help professionals understand the powerful emotions communicated to them via the mechanism of projective identification can enable them, in turn, to be more available to the children and their carers."* (p.168)

Data indicated that participants often sought to implement a similar skill set when working with professionals as they did when working with their patient group. Along with offering insight, interviews indicated that participants viewed themselves as playing a 'maternal function' for related professionals within supervision and consultations, most noticeably by providing 'containment' and a space to 'digest' the problem at hand. This was referenced in the data through participants' descriptions of attempting to 'slow down' referrals that could come to their services in a state of panic, and to contain professionals' anxieties that may have been stirred up through their contact with the patient or family. Other participants described the relief of professionals who were able to make use of consultations to bring their concerns and to *"be able to talk to somebody about this".* These reported experiences relate strongly to Emanuel's (2002) considerations on her casework interactions with social workers. She reflects that, "*It can be a great relief to professionals to recognize that their feelings of distress or inadequacy may, in fact, be emanating from a child or a birth parent, who is passing on unbearable feelings of upset or failure about their own parenting, to the social worker, who has to tolerate them on their behalf*." (p.168)

Other participants shared different and more challenging experiences of their liaison with other professionals. One participant's comment that one has to *"sell yourself"* captures a subtle but nevertheless important aspect of their role which is worthy of further consideration. This reflection implies that a child psychotherapist might have to take quite an active role in engaging other professionals rather than relying on professionals seek out support from a child psychotherapist. The comment brings to mind an image of a child psychotherapists as something of a door-to-door salesmen, traveling out into the community and needing to 'interest' other professionals in what they might have to offer, which at times, might be felt to be something other professionals do not want to buy into.

This point of consideration raises the question of why, when the prevalence of complex cases in an area is high, might it be such a challenge to 'sell' (or even give away) knowledge and insight which may be supportive to professionals and to the families they work with. Another participant's insight, when describing an interaction with a professional is of use when examining this, suggesting that the professional found the

"*focus on emotional experience… just really difficult*" and that, "*it can stir up so much about peoples own experiences, their own attachments, maybe their own attachments with their own parents*". Here, this participant appears to be alluding to pain and difficulty that close examination of bonds and attachment might uncover, and to the defences that all individuals will bring to their work, in some form or another. It also speaks to the universality of the subject of mothers and infants and of the legacy left from our own experiences in infancy, which, if too painful may lead to defensive blocking out of any awareness of its importance. Reflections from both participants indicate that at times child psychotherapists might first have to bear rejection, hostility and a multitude of other complex projections before productive inroads can be made.

In relation to knowledge sharing with other professionals, a common thread that ran through the interviews was the observation of the amount of time that it could take to 'build-up' understanding in colleagues and professionals, with participants reflecting that patience, care and tact were needed as well as regular opportunities to interact and share the 'psychoanalytic perspective' to allow it to become gradually embedded. Daws' (1985-2005) descriptions of her 30-year psychoanalytic presence and place working within a baby clinic provides something of a 'best practice' example of efforts made to gradually embed psychoanalytic understanding around infancy into a non-psychoanalytic professional workplace and demonstrates an admirable level of patience and commitment to the task. However, it also serves to highlight the complexity of the task of sharing psychoanalytic thinking with the wider professional network and indicates that a steady relationship with a service over a length of time is necessary within this endeavour. Participants interviewed within this research described efforts made to establish these sorts of connections with professional groups such as health visitors, midwives, or to offer multi-agency case discussion group with a focus around infancy. Whilst some participants seemed to have managed to set up and maintain such groups, others had not, having often undergone repeat experiences of being rebuffed by related professional groups. The success or failure to implement such groups did not appear related to the clinical expertise of the participants and appeared to bear greater relation to the state of health and functioning of the network.

5.2.4 Theme D - Duty

The theme of ‘Duty’ was used to capture a sense of concern and felt moral obligation that existed within the data set, which include a sense of standing up for the rights of the baby, described in the subtheme ‘making the invisible baby visible’ and an overarching concern for the state of other services tasked with supporting children under 5’s, reported in ‘health and functioning of the network’.

The duty of ‘making the invisible baby visible’ clearly documented in the data set as running concurrent with the ‘work’, ‘task’ and ‘position’ that the participants took up within their role. Within the clinical work, all participants gave indication that they viewed that an important aspect of their role was to give the baby or young child a voice, which could include speaking to the baby / young child, actively including them in sessions, and making interpretations about their needs or feelings in the moment in order to support parents in thinking about their baby or young child’s communications.

Participants described also taking up this duty when working within their teams and with other professionals in the related network. A number of participants described, with some frustration, instances where a young child’s needs had been ‘overlooked’ due to a prevailing belief that young children cannot remember what happens to them. When needs of a young child were visible, and not easily overlooked, participants viewed that some professionals retained the belief that difficulties would simply diminish as the child got older.

The prevalence of observations from participants about the need to make sure the infant doesn’t get forgotten or ‘overlooked’ and to reinforce the importance of early experiences suggests that this phenomenon may be common within networks of early years professionals and is worthy of further examination. It is highly likely that all, if not most, front line professionals working with infants, young children and mothers would have some awareness of infant mental health and the longstanding impact of adverse experiences or attachments formed in infancy can have. With this in mind, one, might assume that some professionals may hold an awareness of the importance of infancy whilst simultaneously not allowing themselves to be fully aware of this fact. As communicated by participants they held that an aspect of their role was to maintain this awareness in others, ‘to take and stand’ and to ‘be that voice’.

Within this subtheme, two participants offered insight into why the infant might get overlooked. One referenced how difficult it can be to spot some of the subtler signs of disturbance in infancy, which might include withdrawn behaviour in infancy, gaze avoidance and freezing (as documented by Fraiberg, 1976) or excessive muscular tension such, understood as a consequence of 'second skin formation' (Bick 1968) and that these subtle signs might remain unrecognised by professionals tasked with working with infants and young children. A second participant reflected that it is difficult for professionals to 'put themselves in the baby's shoes', suggesting that professionals, indeed all adults, will not remember their own infancy and that it is simply very difficult to imagine what it might be like to have no words and to be completely dependent on another. Whilst child psychotherapists too will have no recollection of their own infancy, they will carry with them the embedded understanding and recollection of the experiential learning amassed by conducting their own infant observation for a two year period as part of their training, which is likely to significantly heighten their awareness of the communications and needs of very young children and, as observed within the participant group, may lead them to take up positions to advocate for them, in sessions, in conversations with professionals and too, at a policy level, providing a voice for children too young to speak for themselves.

Participants views documented in the subthemes 'what is the problem?' 'who is the patient?' and literature documented within the literature review explore the notion that difficulties recognised by professionals and parents alike may present or be understood as somatic difficulties (Emanuel, 2012; Daws 2008), viewed through a diagnostic lens as behavioural difficulties such as ADHD or neurodevelopmental difficulties such as ASD (Emanuel 2003) or viewed the lens of the parent's perception of their young child, which, due to the power of unconscious projections and projective identification, can be vastly distorted or else lead to a distortion of the actual behaviour of the infant (Daws 2008; Williams 1997; Fraiberg, 1975; Seglow and Cannon, 1999). What appears to get lost or overlooked is the relational experience and the 'truth' of the pattern of relating that an infant is engaged in with their parent. It is this experience, with all it's significance, that participants seemed to feel duty bound to make visible, keep in the minds of others and represent in their interactions with other professionals.

The subtheme ‘making the invisible baby visible’ also included a challenge raised by some participants (most noticeably those holding clinical lead or managerial responsibilities) to hold services, commissioners and governmental groups to account ensuring that policy makers and commissions did not just ‘pay lip service’ to the mental health needs of the infant but designed and properly funded services to meet these needs. It was noted by two participants that despite rapidly increasing awareness of mental health needs in infancy and early childhood, alongside the importance of early intervention, many local CAMHS teams could fail to provide a service for children under 5 years old, with resources being disproportionately skewed towards adolescents. One participant suggested that the voice of the infant or young child might get lost in CAMHS due to *“services lack[ing] confidence”* in their understanding of young children. They outlined their view that child psychotherapists need to be prepared and adequately trained to take up this position in the teams they work within.

The theme ‘duty’ also captures a further concern or preoccupation held by some of the participants around the health and functionality of the network. These included concerns about underfunding and aggressive cuts made to other under 5 services in the local authority, concerns around staff in these services being “*hugely overloaded”* and “*not very well looked after”,* circumstances which were observed by participants as linked to burnout, emotional shutting down and high staff turnover.

Due to the interlinking nature of child psychotherapist’s role with that of other professionals (documented throughout this discussion), the health and functionally of their surrounding network is valid concern as signs of ‘ill health’ in the network such as high staff anxiety, high turnover, levels of burn out or defensive emotional shutting down are all likely to impact the role of a child psychotherapist considerably. Participants within this study have indicated that the point of referral can be an area of complexity within the role. For the right referrals find their way to a child psychotherapist (and within a timely manner), referrers, who come from all areas of the broad network surrounding infants and young children, need enough time and space to notices the needs of infants within their care and to make a referral. Prior to making a referral, referrers must already hold some knowledge of infant mental health difficulties and subscribe to the notion that these difficulties matter. As examined earlier in the

discussion, participants have also referred directly to and alluded to the importance of having established relationships with referrers and to the time it takes to gradually embed an understanding of infant mental health in related services and within the network. This amounts to a considerable and necessary input from child psychotherapists working in this specialism which is all but lost when staff turnover in related professional services is high or when culture change within surrounding organisations is frequent. One participant represented a concern about the level of defensiveness that could develop in individuals and organisations under pressure, indicating that when under extreme pressure, organisations and professionals can develop defensive patterns of managing service and personal anxiety, leading to the risk of a shutting down in thinking or the development of immunity to the distress within the patient group, with staff turning away in order to protect themselves from intolerable anxiety. This echoes concerns outlined by Britton (1981) Evans (2014; 2020) and Emanuel (2002), as well as the observation that health care institutions can develop entrenched patterns of defences, as popularised by Menzies-Lyth (1959).

5.2.5 Theme E - Lived Experience

Complexities, frustrations and challenges of the role of the child psychotherapist working with under 5's have been considered throughout this discussion and it appears that an aspect of the 'role' is to be able to manage the burden of the role. This burden includes the emotional impact of working with and witnessing difficulties in the parent - infant relationship, which may be particularly painful where parental mental health difficulties as present, or where the infant might present as distressed, frightened, or withdrawn. This emotional impact may too be particularly 'felt' by child psychotherapists due to the necessity in the therapeutic work to remain open and sensitive to the unconscious primitive anxiety which may emanate from young children, parents, and professionals alike, or else may arrive powerfully in the therapist in the form of projection.

Participants described frequently engaging in outreach work, regularly working with different families, different sets of professionals and within different outreach settings. As Daw's (2005) reflected, one needs *"very thick skin"* to work in an institution that is not one's own and it could be supposed that conducting work in multiple institutions

that are not one's own might require very thick skin indeed! One can't help but notice the inherent difficulties that might ensue for child psychotherapists needing to alternate between states of being suitably armoured to manage the difficulties inherent in conducting outreach work and suitable open and receptive enough to engage in therapeutic interactions with patients and families, which requires them to approach their sessions with an "*attitude… of openness to exploration of all communications from parents, infants, and child[.]"* (Bradley and Emanuel 2008, p.6) and to be able to "*stay with the psychic pain*" (Wittenberg, 2008, p.36)

The impact of this type of work on child psychotherapists engaging in it is not extensively explored in the literature on the subject, and accounts in literature can, at times, give the impression of child psychotherapists as possessing a limitless capacity to remain open to and tolerant of psychic pain without becoming overwhelmed. Whilst this impression was to some extent present within the data set, interviews indicated that the burden of engaging in this role weighed could quite heavily on participants, could lead to feelings of frustration and loneliness in the work and could bleed into their personal lives, leading to difficult reflection on their own families and parenting.

Interviewees indicated that the role that a child psychotherapist held with families and within networks had complex relational components to it, whereby the function that a child psychotherapist played could vary seemingly independent of their skill set. The data provided some indication that families and professionals might place psychotherapists in certain positions, casting them in roles such as 'expert' or 'useless', 'helpful' or 'persecuting' which may relate to the conscious or unconscious ideas / beliefs of individual families, professionals or services. Navigating the relational aspects at every level of the role thus appeared to be a further significant aspect of the role of child psychotherapists working with under 5's. One could speculate that the unconscious relational aspects of the role may be particularly pronounced in under 5 work due to the high level of primitive anxiety present in this age group of children, stirred up in the families, which resonated throughout the wider network.

It is important to note too that whilst participants were able to reflect on their concerns for frontline staff, they too are frontline staff, subject to the pressures of everyday services, and not immune to the pull of organisational defences and to feelings of resentment, hostility or burnout which may be managed by locating them in other

professionals. If this is the case, one might intuit too that they must be protected and looked after in their professional roles.

Despite the evident complexity of the role, some participants were able to reflect on the more positive aspects of the role, which include feeling, as child psychotherapists, well trained and well placed to be of service and use to the under 5 network. Implied throughout the data set was a passion and interest in the work and within some interviews a clear drive and ambition to 'fight the good fight' and make a difference in the field of infant mental health. Some participant referenced the sense of joy and accomplishment felt when change, even in small forms, was witnessed throughout the course of an intervention, echoing Wittenberg (2008) assertion that, "*To witness relief, greater tolerance of the difficulties involved in being a parent, and the ascendancy of love towards the baby arising out of greater insight is a wondrous, humbling and gratifying experience for any therapist."* (p.18)

5.2.6 Reflexivity

The process of designing, conducting and analysing one's own research is by no means a mechanical process but is a personal and lively experience. Whilst a conscious attempt to stay loyal to the data has been made at every step of this research, my own background of completing part of my clinical training in an under 5's specialist post and other previous professional roles I have held have no doubt shaped the design of this research as well as the arrangement and considerations of the themes documented and discussed within the final sections of this paper. For this reason, it may be apt to think of the researcher, myself, as the final participant of the research.

My professional working life thus far has often led me to consider the interplay between and individual's pathology and the layers of systems around these individuals, be they family systems or professional systems. This interest may in part have directed me towards the specialism of under 5 work, where the pathology of young children is seen and inseparable from the family / parental pathology, but is

also present within this research and in the choices I have made when designing the research and in ordering the themes generated within it.

The experience of conducting the live, spoken interviews for this research added another layer to the analysis of the results. As researchers, transcripts can tell us what was said in by participants within interviews, but live recordings and experiences with participants can tell us how it was said. As a qualified child psychotherapist myself, I feel I may be particularly sensitive to paying attention to the way in which something is communicated and thus the tone of the interviews likely acted a further and important aspect of the data, perhaps even helpfully influencing the way in which the data was understood and analysed.

5.3 Strengths and limitations

Strengths and limitations of this study should be noted when considering the results.

Strengths

This is a novel study examining child Psychotherapist's understanding of their role when supporting children under 5. Participants ranged in experience and positions in their organisations and the study sought to include participants working throughout the UK and across multiple different services, thus the study could be considered to bring together a broad range of experiences.

This research also considers the breadth of the role that under 5's child psychotherapists consider themselves to play, examining aspects of the role that exist beyond the clinical work, some of which have not been discussed or captured in previous research or clinical writing. Due to its focus on multiple areas of the role of child psychotherapists working in this specialism, this research may also highlight areas of conflict and tension that exist between aspects of the role and capture the complexity of managing different aspects of the role simultaneous. Whilst the research primarily focuses on the role of child psychotherapists working with under 5's, the findings and discussion of this research, particularly those relating to the role that child psychotherapists outside of direct clinical work with patients may well be recognised as complex aspects of the role

of child psychotherapists working in a broad range of specialism. As such, this research may be of value to child psychotherapists working outside under 5 specialism as well as those working within it.

Similarly, an aspect of this research considers the notion of the 'role' of child psychotherapists which may be of interests to professionals working in related disciplines as well as professionals working in service design, and at a management and commissioning level.

Limitations

Despite my attempt to include participants from across the UK and of different ages, genders and ethnicity, the actual sample group that took part in this study were quite homogeneous. Participants were predominantly working in the greater London area, were white, spoke English as a first language and were observed as likely to identify ethnically as 'white British', though specific data on this was not collected or asked for. For this reason, it would be prudent to exercise some caution when considering the generalisability of these results as do not reflect the experiences of all child psychotherapists working with children under 5, and unintentionally bias the experiences of white child psychotherapists working with under 5's in the greater London area.

Research was conducted by me, working as sole researcher as part of a doctoral degree. My interest in the subject was borne out of my experience working as a child psychotherapist in training in a team catering for children from the ages of 0-4 and thus I came to the research with my own experience of holding a similar position to those interviewed. Though effort has been made to by me to process and bracket off my own experiences and to collect themes from the data using an inductive approach, it is possible that interpretation and organisation of the data may have been influenced in some way by my prior experience.

This was a small-scale study, comprised of only 7 participants. Participants eligible for this study were estimated to be few (likely no more than 40 across the UK) I, the researcher, had met several of the participants prior to the interviews taking place and

due to the small number of eligible participants working in the same field, it is likely that participants knew or may have met other participants over the course of their professional lives. For this reason, it is possible that participants were aware of the experiences and challenges faced by other participants working with under 5's (discussed in conferences, etc) which could have led to contamination in the data in some small but unmeasurable way.

5.4 Future research

This research highlights the breath of the role that child psychotherapists view they play in the under 5 network, providing something of a broad overview. Further research could seek to explore the single aspects of this role to a greater depth to gain deeper and more nuances insight in this area. The research indicated that a growing area in under 5 work that some participants were engaged in was 'group work' with under 5's, with several different models being used and adapted by child psychotherapists. Future research could helpfully explore the process and efficacy of such group work.

Taking a broader view and moving away from a focus on under 5's, this research raises some questions about the place and compatibility of psychotherapy in the NHS, in the modern climate, which could be usefully explored through further research.

Touched upon within the results and discussion of this research was the emotional impact of the role that child psychotherapists perceive they play, which is likely accentuated due to the need for clinicians to remain open to and to be able to stay the psychic pain present in the families attended to and in the clinicians themselves. Though it was not referred to within the data set, it is possible that one's experience of undertaking one's own personal analysis for the required minimum of 5 years during the training of child and adolescent psychotherapists is likely to play a role in supporting child psychotherapists in managing this burden. This would be another area worthy of thorough exploration in future research.

5.5 Conclusion

The aim of this small-scale research study was to examine how child psychotherapists understood their role when working with children under 5 years old, their families, within their teams and within the wider network of professionals around them. Within this examination, broader aims were to gain further insight into the current working practices of and challenges faced by child psychotherapists engaged in under 5 work and to explore the notion of a child psychotherapists' 'role' within the context of working with under 5's, their families, their teams and the surrounding under 5's professional network.

The findings of this study suggest that the role of child psychotherapists working to support children under 5 years old is viewed as complex and multifaceted. The role includes providing clinical intervention to young children and families as well as playing an active role in the network of professionals around them which can, at times, be as complex as the clinical work itself. Outside of direct clinical work, child psychotherapists indicated that they held an ongoing and active role within their teams and within the network around them. Child Psychotherapists interviewed described several complex factors involved in this aspect of the role, which included managing the gap between the 'psychoanalytic view' of infancy and young children held by them and the different views held by others in the extended network. Participants indicated that in both clinical work and network liaison, they viewed that an aspect of their role included 'representing the voice of the baby' and communicating this to parents and professionals alike. Taking up this position could be met with mixed reactions. Participants described that on some occasions, providing space to think about meaning and the baby's experience was well received and appeared experienced by professionals and parents as helpful and supportive, whilst at other times it could be met with hostility. The differences in reactions were understood primarily through the lens of defences, both in families, in professionals and services as a whole. Effectively navigating this position appeared to constitute a large part of the role of the child psychotherapists and indicated that the therapeutic capacities of the psychotherapist, such as providing containment and understanding / navigating defences extended and where actively used well beyond the clinical work but also in work within teams and the wider network, appearing relevant in every layer of the roles that child psychotherapists viewed themselves as holding. Child psychotherapists also perceived

themselves to play a role in relation to knowledge sharing and formal or informal teaching in relation to infant mental health. It was considered that these were core aspects of the role of a child psychotherapist within this specialism and were aspects that may not typically be captured or considered as part of their role. Additionally, this study identified several areas of conflict perceived in the role of the child psychotherapist, predominant amongst these was the task of fitting the clinical work into systems in which it did not easily fit.

This research indicates that the role of child psychotherapists within the under 5 network is broad and complex, and that the activity that constitutes the role of a child psychotherapist was perceived to extend greatly beyond what might be typically captured by outcome monitoring. The research indicates too that the role of a child psychotherapist working with under 5's does not exist is isolation but is best viewed as part of a system, within the culture of a team and a system of services. Due to their interconnected nature, the 'wellness' of surrounding services was understood to impacted the role of child psychotherapists. As accrued understanding of infant mental health within the referring body of professionals directly impacted on referrals to child psychotherapists, the level of burn out and staff turnover within this body of professionals could create additional burdens for child psychotherapists working in this specialism.

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Appendix A - NOCLOR confirmation email

Doctoral research project , Tavistock and Portman NHS Trust.
Sent: February 21, 2019 1:10 PM

From: NOCLOR, Contact (CENTRAL AND NORTH WEST LONDON NHS FOUNDATION TRUST)

To: Anna riddiford

Dear Anna,

Where a project is considered to be non-research, it will not be managed as research within the NHS. Based on the email trail and information that we have received from you, you will not need to register with us, nor seek our permission for commencement of this project. However, you will need to get the approval of the service in which the study will be conducted prior to the study commencing and also ensure that you have followed the process at T&P regarding your project. I have copied the Clinical Governance & Quality Manager (Irene Henderson) into the email as you need to satisfy the requirements and complete the process with them at Tavistock & Portman NHS Foundation Trust.

Kind regards,

Mabel Saili
Research & Development Manager
Direct: 020 3317 3756 Team: 0207685 5949

Appendix B - Public facing documents.

i) Advertisement email to potential participants.

Subject: Research doctorate examining the role that child psychotherapists play in working with under 5's - looking for Child Psychotherapists to interview

To: x
Dear x

I am a Child and Adolescent Psychotherapist in training currently completing a research doctorate examining the role that child psychotherapists play in working with under 5's, their parents/ caregivers and the professional network around them. This is a small-scale research project interviewing child psychotherapist who are working predominantly with under 5's. If you are willing, I would be interested in interviewing you and would value your contribution. Interviews would last for approximately an hour and can take place on the phone or via Zoom. I am happy to send more information about the research or to answer any questions you might have.

Many thanks,

Researcher A
Child Psychotherapist

ii) Participant information sheet

Research Project

How are Child Psychotherapists in the UK currently approaching the task of working with children under 5 years old, their families and the professional networks around them?

You are being invited to take part in a research study. This information sheet describes the study and explains what will be involved if you decide to take part

Purpose of the study

This study aims to examine the range of work that Child Psychotherapists in the UK are currently engaged in, which relates to supporting the mental health of children under 5 years old, through work with under 5's, their parents and caregivers and the professional networks around them. This study also aims to collect and explore the professional opinions of child psychotherapists about the work being undertaken, including reflections on perceptions of successes, limitations and barriers to successful work.

Who is conducting the study?

My name is Anna Riddiford. I am a Child and Adolescent Psychotherapist in clinical training and am conducting this study as part of my professional doctorate in Child and Adolescent Psychotherapy. I am undertaking my professional doctorate through Tavistock and Portman NHS Foundation Trust. The professional doctorate is accredited by the University of Essex.

Participant requirements

I am seeking qualified Child and Adolescent Psychotherapists from across the UK who regularly work with children under 5 years old, their parents or carers and/or the professional networks around them. Child psychotherapists who would like to participate must be registered members of the 'Association of Child Psychotherapists' and must be currently engaged in work with under 5's, either directly or indirectly.

What participating in this research will involve?

I plan to interview between 8 – 12 Qualified Child Psychotherapists from a range of services across the UK. The Interviews will take a semi structured format and will last for 40 minutes – 1 hour. Interview questions will be provided to participants in the weeks prior to the interview taking place. Participants in this study will not be require to prepare for the interview ahead of time, but may find it useful to consider the questions prior to the interview taking place.

This piece of research is being conducted through the Tavistock and Portman NHS Foundation Trust. If convenient, interviews will take place within the Tavistock and Portman Clinic (120 Belsize Lane London, NW3 5BA). Where this is not convenient, alternative arrangements can be made.

Involvement in this research is voluntary and participants are free to withdraw consent and/ or unprocessed data at any time.

What will happen to the information I give?

Interviews will be digitally recorded and transcribed. All personal information that I have about you and all information collected and recorded during interview will be kept confidential. At point of transcription, interviews will be anonymised. Your name and contact details will be kept separately from your transcript. Information given in the interview that could be used to identity you will be removed from the transcript. Information that would clearly link you to a particular location or service will be altered to preserve anonymity.

Any extracts from your interview that are quoted in written work will be kept entirely anonymous. Interview transcripts and personal information will be retained and disposed of in accordance to the university's data protection policy.

Please note that confidentiality of data is subject to legal limitations.

What are the possible benefits of taking part?

There are no immediate benefits to taking part in this study. However, Child Psychotherapists taking part may benefit from having the opportunity within the interview to collect, examine and share their experiences and thought.

This research has received formal approval from Tavistock research and development department, TREC

Contact details

I am the main contact for this study. If you would like to participate or have any further questions about the study please don't hesitate to get in touch.

My contact details are:

[REMOVED]

iii) Consent form

NHS
The Tavistock and Portman
NHS Foundation Trust

Consent form

Project title: How are Child Psychotherapists in the UK currently approaching the task of working with children under 5 years old, their families and the professional networks around them?

- I confirm that I have read and understood the information sheet provided for this study. I have had the opportunity to consider the information, ask questions and have had these questions answered satisfactorily ☐
- I understand that my participation in this study is voluntary and that I am free to withdraw at any time, without giving a reason. ☐
- I understand that the interviews will be digitally recorded and transcribed. ☐
- I understand that information given in this interview may be used by the researcher in future publications, reports, or presentations. ☐
- I understand that any personal data or information that could be used to identify me will be removed from the transcript of the interview and that I will not be identified in any future publications, reports or presentations. I understand that confidentially is subject to legal limitations ☐
- I understand that the anonymised transcript of the interview will be kept for no longer than 3 years and will then be deposited in the UK Data Archive. ☐

Participant's name (Printed): _____

Participant's signature: _____ Date: _____

Researcher's signature: _____ Date: _____

Thank you for agreeing to take part in this research.
Your contribution is appreciated.

Appendix C – Interview schedule

Interview Questions

Purpose of the study

This study aims to examine the range of work that Child Psychotherapists in the UK are currently engaged in, which relates to supporting the mental health of children under 5 years old, through work with under 5's, their parents and caregivers and the professional networks around them. This study also aims to collect and explore the professional opinions of child psychotherapists about the work being undertaken, including reflections on perceptions of successes, limitations and barriers to successful work.

Structure of interview

During this interview we will discuss the following 9 questions. The questions are arranged in two parts.

In Part A of the interview I am aiming to gain an overview of the work and activity that you, as a Child Psychotherapist are currently engaged in or have engaged in within the last 2 years, which relates to supporting children under 5 years old.

Part B of the interview invites a more open reflection on the work that you have recently or are currently undertaking in relation to supporting children under 5. I welcome any thoughts, feelings, opinions and observations from participants.

Part A

Q1: Please briefly describe your current service.

Q2: How are under-fives referred to your service and to you as a child psychotherapist? Typically who is making these referrals?

Q3: Could you describe the range of presenting issues with children under 5 and parents/carers referred to you?

Q4: What work or activity are you engaged in that relates to supporting the mental health of children under 5?

Within this question I am interested in the full range of activities that you engage in, in relation to children under 5. This work may be;

- long term,
- short term

- Direct, with children under 5 children and families
- Indirect, with parents / carers alone.
- Consultation or supervision to other professionals,
- Working with groups
- In addition, this activity may be formal activity, or informal activity.

Part B

Q1: I would like to hear a little more about your experience working **directly with children under 5 and their families.**

From your point of view, what is the value of this way of working, what are the limitations of this type of work and what challenges are regularly encountered.

Q2: I would like to hear a little more about your experience of working indirect to supporting children under five. This may involve contact, co-working or supervision with other professionals in the under 5 network.

From your point of view, what is the value of this way of working, what are the limitations of this type of work and what challenges are regularly encountered.

Q3: This question relates to the structure of your service and other local under 5 services.

You are invited to reflect on the place that your service holds in the network of services around you and the place of yourself as a child psychotherapist in this network.

Q4: Looking forward, how do you think Child psychotherapy / Child psychotherapists could best be utilized in relation to work that supports the needs of children under 5?

Q5: This interview has been composed to explore Child Psychotherapy's current working practice with Children under the age of 5 years old and thoughts on this practice.

Are there any topics which have not been covered within this interview which seem relevant to this exploration or any additional thoughts or reflections that you would like to share?

Appendix D - Excerpt of coded interview.

Coding	Interview (2.22)	Code Key
	Part A	(D) - Description of service (OR) - Outreach work (HV) - Home visits (Com) - Community (PP) - Pre-birth/ pregnancy/ in-uretero (CW) - Cross agency/ discipline working (T) - Trauma (LA) - Looked after (DV) - Domestic Violence (BD) - Behavioural difficulties (AMH) - Adult mental health (PIR) - Parent -infant relationship (ED) - Emotional difficulties (TD) - Transgenerational difficulties (LT) - Long term (ST) - Short term (PVP) - Sharing the psychoanalytic view point and consultation (EI) - Emotional impact of work (P?) - Who is the patient? (Pr@) - Projections (QD) - Looking for quick diagnosis (S/R) - Safeguarding and risk (lims) - Limitations of service (C) – Containment (P/A) – Panic and Anxiety (DTP) – Different theoretical positions (IB) - Invisible Baby (RCP) - Reflections on role of child psychotherapist when working with parents and infants
	Q1: Please briefly describe your current service.	
D PVP	I work in the B. CAMHS under five and perinatal service which is a CAMHS team - pre-birth to 5 and working with children and their parent carers. The service does a combination of direct clinical work and with families and then also has a role of consultation with the prof next work in various ways, which i might go into later, is that enough?	
	Can i ask where you are housed - are you in a multi disc. Team or on your own?	
CW Com HV PP D	So Under 5's and perinatal service is MDT i am one of 2 child psychotherapists and we also have a clinical psychologist and the team manager there is a social worker, its a relatively small team and we sit within the overall CAMHS service - based in the main CAMHS clinic but quite a lot of the work takes me into the community so whether that is home visits or working in Children's centres. I should say that the under 5's service has been around for many years but the perinatal - pre birth to 1 pathway is a relatively new thing within the last 2 years and that's when I started in the service and helped to develop that aspect of it. I think it is an unusual - well it's unusual to have an under 5's service generally in CAMHS but also its really interesting to have a perinatal aspect to the under 5's so it is an interesting aspect of the work.	
	Q2: How are under-fives referred to your service and to you as a child psychotherapist? Typically who is making these referrals?	

CW PVP D PVP CW	So over the years the CAMHS under 5's team has built strong links with various different agencies in Bexley and i would say the main source of referrals is HV, SC often refer and midwives, GP's and we will receive referrals directly from all of these sources. We also have a monthly Multiagency case discussion forum one of PN and one for the under 5's where cases are thought about and professionals from different agencies bring different cases and we may make recommendations that cases will be referred in to CAMHS. So these referrals come directly to the team and then we think in our team meeting which takes place every 2 weeks and then we think about how those cases are allocated. We are a very small team, so its either myself or Clin Psych. The team lead probably won't take on so many cases as me or the clin psych. So that's how the actual case might come to me as the case co - through the team meetings,	Code Key (D) - Description of service (OR) - Outreach work (HV) - Home visits (Com) - Community (PP) - Pre-birth/ pregnancy/ in-uretero (CW) - Cross agency/ discipline working (T) - Trauma (LA) - Looked after (DV) - Domestic Violence (BD) - Behavioural difficulties (AMH) - Adult mental health (PIR) - Parent -infant relationship (ED) - Emotional difficulties (TD) - Transgenerational difficulties (LT) - Long term (ST) - Short term (PVP) - Sharing the psychoanalytic view point and consultation (EI) - Emotional impact of work (P?) - Who is the patient? (Pr@) - Projections (QD) - Looking for quick diagnosis (S/R) - Safeguarding and risk (lims) - Limitations of service (C) – Containment (P/A) – Panic and Anxiety (DTP) – Different theoretical positions (IB) - Invisible Baby (RCP) - Reflections on role of child psychotherapist when working with parents and infants (WF) Working flexibly
	Q3: Could you describe the range of presenting issues with children under 5 and parents/carers referred to you?	
T LA DV PP BD AMH	It's quite broad - and in a way i would see a difference between the pre-birth to 1 and the under 5's bit. In terms of the under 5 age range, so it's quite a wide range of symptoms and family backgrounds., it may be children that have experienced some kind of trauma - not usually one kind of trauma but compound trauma - so maybe neglect or abuse and sometimes that would be, sometimes they might already be looked after children, so my team actually works quite closely with the LAC team and our service, so the team manager and the clinical lead actually crosses over between those two teams so we do have some LAC cases. I am just trying to think… so domestic violence, and children growing up in an atmosphere of domestic violence and that can be as children or even in utero. Challenging behaviour is a real classic referral to us - that can take a number of forms - aggressive outbursts or emotional outbursts or 'meltdowns' is one of the most common things I see on the referrals, so behavioural difficulties, I am sure there are loads more that i am not capturing now. But in terms of the perinatal side of	

Appendix E – Exert themes and sources of data

Theme	Source of data
Task	*"so much of under 5's 'presentation' is about what they are actually doing, like hitting, biting, not sleeping, crying. And [referrers and parents] want it to be about something quite physical when often it's a manifestation of something unconscious that we haven't quite got to.".*
Patient	*"the strength and force of the projections that go with the parents into their child… [is] quite a challenging aspect of the work particularly with work under 5's. Quite a lot of the pathologizing from parents into their children about what's wrong with my child, quite often wanting a diagnosis"*.
Problem	*"It can be confusing who your patient is. Are you working with the parent or the carer are they your patient or is the child your patient and that can be quite difficult confusing in under-fives work. You are having to balance two aspects of the work and essentially, like I said, your patient is the relationship between the two. So, it's almost as if you're juggling three things; the parent, the baby and the parent baby relationship".*
Multiple points att.	*"But is also about helping parents think about their experiences of being children and how they were parented. So, I think the real value of being a child psychotherapist is that we often think across time zones, so we can think about the past and the present. And we can hold these multiple time frames and if we can help parents think that through, it can be that that can release the child from those negative projections that are going on".*
Maternal function	*"We were working on the floor with mother and baby treating baby as a separate person with the mind and he was a participant in therapy and thinking a both in the here and now, about mothers feelings and concepts and ideas about her baby and also looking at the baby as a thinking, feeling person who is acting and responding and developing a conversation and a dialogue and discourse with the mother about that and looking for examples of phenomena in the here and now such as the babies gaze points and what the mother might feel about that and what the mother might see when she looks at her baby and then secondly thinking about her history and how that applies"*