Tales of the unexpected: What needs to be understood by a child psychotherapist when taking up their role working with under-fives in a mental health service?

Reflexive thematic analysis of professionals' experiences

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Abstract

This is a qualitative study which sought to understand professionals' experience of and views regarding their roles as providers of services and/or personnel serving under-fives' mental health and wellbeing. The study was prompted by anecdotal controversy regarding views on how under-fives' mental health and wellbeing needs are met. Fifteen professionals, from a wide range of children's services, took part in interviews which were analysed using reflexive thematic analysis. It was hoped that prior controversy could be understood through analysis of dialogue with professionals.

Existing research literature, exploring professional experiences, found that they expressed a range of disturbing emotional states in the course of their work encountering distressed under-fives and families. Variations were highlighted amongst inter-discipline/-agency working experiences with mixed perceptions regarding what constituted barriers and/or successes in meeting under-fives' needs. Some reported that integrated multi-discipline services were best. Others felt it was more about how services or disciplines communicated with each other rather than the level of integration or separateness of team/service organisation. Findings from existing literature presented variations regarding solution ideas.

Thematic analysis, using a psychoanalytic lens, was conducted and sought to understand meaning in this study's data. Results found echoes with existing research selected in the literature review. Similar emotional experiences were expressed and participants conveyed similar mixed views regarding service integration or separateness, and solutions.

Unexpectedly findings revealed new controversy which seemed associated with systemic factors and primitive internal states. A notable finding was the portrayal of representations of infants by some participants. These conceptualisations appeared almost

concrete in nature and came with ideas regarding how and where they fit into society and/or who might be responsible for their wellbeing.

It seemed likely that the unexpected and notable revelations contribute to the original controversy. Findings demonstrated the complexity of the topic and arena: what is at play concretely and what is unconscious, and how difficult this might be to contemplate within the auspices of the field and what might get caught up and/or result in muddles in the work.

I gained insight and there were lessons for me and other child psychotherapists. In particular, how child psychotherapist's and, separately, CAMHS are perceived and/or experienced directly impacts inter-agency/-service working. Further, and importantly, these factors were found to have implications for the infants and families with whom we work, in terms of treatment pathways. Findings demonstrated how infants, colleagues and services are seen, and/or whether they are unseen, is likely to relate to outcomes for infants/families.

Findings pose significant and interesting dilemmas for the study locality, seemingly highlighting endemic issues which could benefit from further thinking to aid long-term strategies and planning for the under-fives' population.

Key words: infant mental health, under-fives, psychoanalytic psychotherapy, childism, systemic, professional experiences, narratives, qualitative

Contents

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Chapter 1: Introduction

We know very young children evoke emotional responses in adults. 'We are inherently designed to have visceral reactions to each other's actions, mishaps and feelings' (Balbernie, 2007, p308). Klein referred to the 'confluence' of emotional states, wherein 'anxiety' between objects 'centre on the welfare and survival of the other as a whole object' (Bott Spillius et al, 2011, p84). Anxiety can span worry to excitement. Emotional experiences may be understood through countertransference, individual sensitivities, and/or transference of projected sensitivities from young children and by observing their behaviour as communications of their internal states.

As a child and adolescent psychoanalytic psychotherapist, I am keenly interested in dynamics of relationships with under-fives. Working within Child and Adolescent Mental Health Service (CAMHS) this dynamic in its clinical context has become a particular interest: how multi-discipline professionals experience and view mental health and wellbeing difficulties in very young children.

My paper is not about whether under-fives and parents/carers need support during this period of life. There is enough evidence in circulation on this matter already: Bowlby brought to attention 'attachment theory' (1958); Stern identified 'four senses of self' necessary in infant development (1985); and '1001 Critical Days' cross-party manifesto is one of the most current pieces of research being given attention by the Government (2013, 2015). Rather, my paper is about professionals' experiences in the context of their work with under-fives.

My study morphed over the course of events. It was originally conceived from experience within a CAMHS' training placement. I noticed an apparent disproportion between referrals of differently-aged children which I became curious about. Despite the CAMHS' threshold spanning 0-18 years old there were few under-fives' referrals in relation to particularly adolescent, and latency, referrals. My curiosity grew as discussions with a

variety of colleagues revealed different perceptions as to what the discrepancy might be about. Anecdotal views included: under-fives not regarded as experiencing mental health difficulties meaning CAMHS would be irrelevant; alternatively, under-fives' emotional difficulties viewed as better served by medical or social care, rather than mental health, services; alternatively, this age-group were in desperate need of mental health services, but CAMHS were inaccessible.

I embarked on an initial study offering Parent-Infant Psychotherapy to families, assessed as requiring therapeutic support by perinatal and/or health visiting services. Despite the desperate need perception, no participants were identified. It is possible that this was connected to limitations of a trainee doctoral project, e.g. threshold and/or time factors. I wondered however if something more complex, nuanced and/or unconscious was occurring. I re-designed the study to investigate professionals' experiences in an attempt to understand thoughts, feelings and meaning beneath anecdotal impressions.

Professionals from social, mental health and medical services serving under-fives became my focus. My second study invitation prompted many more responses to participate. One account for this might be a sense of something uncontainable or overwhelming about the work with under-fives. The pace and progress of a child's development is a source of anxiety for adults generally, whether parents/carers themselves and/or they have their own experiences of having been parented. The pseudo-parental function of professionals is understandably impacted and felt. This is related to Bion's theory of container-contained (Bion, 1962).

My aim is to understand my discipline in the context of other disciplines, how my role could be enhanced by understanding other disciplines and their experiences with infant mental health, under-fives and families, and inter-agency encounters.

What follows is a literature review providing a foundation which helped inform my study. This is followed by my study and reflexive thematic analysis of semi-structured interviews with professionals. Some parallel and expected findings were revealed as well as some unexpected ones. I identified six themes and discuss them in the light of psychoanalytic thinking. I then draw some conclusions which could inform local inter-agency working.

Chapter 2: Literature Review

The literature review will focus on three principal questions in order to provide a framework: 1. What is emotionally managed by professionals in their practice? 2. What impacts that which is provided by professionals? 3. What impacts inter-discipline/-agency working and outcomes for infants and families?

Du Plock (2014) states a 'literature review is a piece of research in its own right' (p57). A narrative review will follow consideration of Du Plock's (2014) and Booth et al's (2012) guiding principles.

As the name suggests a narrative review is a researcher's story-telling of literature available on a specific topic. It is not an exhaustive review of all evidence amassed on a particular topic. It is selective to serve the purpose of the researcher's enquiry.

Booth et al (2012) argue a researcher's story-telling mean narrative reviews are insufficiently robust and do not withstand scrutiny in the way systematic reviews do. Secondly, they criticise narrative reviewers tend towards complementary evidence to support a narrow subjective lens. Lastly, they state narrative reviews tend to be biased and, therefore, weaker than a systematic approach. Three mitigations to these criticisms will be considered.

Systematic weakness

A narrative review may be considered less exhaustive however robustness needs to be judged on individual merit. It is a review led by the researcher's mind rather than an objective collective of existing research. Researchers remain able to apply a systematic approach regardless. The resultant review can arguably be sufficiently robust with the process being clear and able to be replicated. Robustness does not have to relate to the focus of narrative but rather process reliability.

Narrow subjective lens

A subjective view does not mean narrow by definition. Narrative reviews can seek alternative, broader and/or additional perspectives across research. Pioneering beyond limited boundaries is likely to mitigate the criticism in this regard. Each review needs to be measured by such merits.

The following narrative search was conducted across a wide range of archives to include different disciplines: APA psychinfo; PEP; MEDLINE; SocINDEX; and the Cochran's Library. Widening the lens and deliberately seeking diversity is intended to mitigate subjectivity.

Complementary bias

There would seem little reward in researchers regurgitating and echoing each other. A useful tool in mitigating researcher bias is Luyten's (2015) 'five central tenets of psychoanalysis'. Luyten threw down a gauntlet to psychoanalysis, to consistently challenge and question thinking. Researcher bias can never be entirely eliminated of course but it seems possible to be mindful of it.

Embracing diversity across disciplines and sources is likely to off-set an understandable, and often unconscious, bias by researchers. Narrative reviews can provoke dialogue and further research, and therefore be of value.

Why a narrative review?

A narrative review serves selective and purposeful sampling required for this study: The focus is narrative experiences of participants and a narrative review will mimic this.

It is not feasible within the confines of this doctoral study to conduct a fully systematic or exhaustive review.

It is hoped the following narrative review will present transparent processes enabling replicability.

Narrative Review Process

Despite criticisms, Booth et al (2012) propose guiding principles which identify a systematic approach for conducting narrative reviews. This is exemplified by use of 'representative coverage' (Cooper, 1988a/1988b in Booth et al, 2012, p20) with an 'interpretive goal in mind (Walshe and Downe, 2005, in Booth et al, 2012, p22). The selected studies have been deemed representative of and relevant to the study focus.

To define the scope of the review the acronymic frame SPICE was used: **S**etting, **P**erspective, **I**nterest/**i**ntervention, **C**omparison, **E**valuation (Booth, 2004, in Booth et al, 2012, p57), see table 1.

Setting	CAMHS; multi-discipline services
Perspective	Practitioners/professionals in the service of under-fives mental health and wellbeing needs
Interest/Intervention	Population of under-fives; infants; 0-5 years old
Comparator	Within/between services
Evaluation	Quantitative and/or qualitative studies

Table 1.

The Search

Du Plock (2014) states time is required during the word/phrase search of the process. Words or phrases can be nuanced. For example, 'mental health' was found to be too specific and reductive. Broader terminology proved helpful, e.g. 'wellbeing'. Other words, like 'anxiety', could be assumptive, negative and/or distanced from the human warning system.

This highlights that different words have different meanings in different contexts. There are implications for searches and care is required when combining certain words/phrases.

Eleven searches were conducted with various word/phrase combinations. Exclusions were made according to geography, age, language, and ethnicity. Exclusions attempted to identify homogenous and comparable populations and cultures. Studies, or parts thereof, were excluded if they were irrelevant to the professional experience. Repetitions were excluded. Date parameters focused the search between 2000-2020. As Infant Mental Health is a rapidly developing field literature needed to be relatively current to be relevant.

Some studies came to attention through 'snowballing' or happenchance via recommendations and personal reading. Appendix I exemplifies one of the 11 searches. Appendix II lists reference sources which did not make final selection. Not all were scrutinised in depth.

Before heading into the empirical literature of the review, there is a brief orientation narrative.

Brief context

From a psychoanalytic perspective it is paramount to understand emotional encounters with very young children for three significant reasons: Firstly, in order to survive infants have no other resources or means other than to project their raw emotional states and needs externally. They are understood as communications of their anxiety and/or need, and come with an expectation and/or anticipation, a wish they will be survived, and safe equilibrium restored. This is hugely challenging for mothers, and parents/carers generally, having, of course, their own needs and multiple life/everyday demands to manage too.

> *In its earliest forms projective identification has no concern for the object — indeed, it is often anti-concern, aimed at dominating, irrespective of the cost to the object.* (Joseph, 1984, p169)

It is a natural defence to protect ourselves from infantile projections. Sometimes there is need for support and/or intervention to manage.

Secondly, when mothers/parents/carers are unable to receive, contain and modify those projections and/or infants/young children are exhibiting symptoms of emotional and identity struggles, practitioners need to be able to fulfil this role for the infants/children and the family members too.

The function of workers to be survivors of projections is referred to by Bradley and Emanuel (2008). Survival conveys the power of the emotional arena of the work.

> *Professionals find themselves swamped by unconscious projections from their clients which affect their powers to work and to think. We find ourselves feeling stupid, helpless, blind to the obvious, or full of uncomfortable responses tinged with contempt, anger, or rejection.* (Bradley and Emanuel, 2008, p135)

Thirdly, our own infantile experiences and feelings, despite maturity and/or training, remain resident internally and can be triggered unconsciously.

> *Just as we recognise the "infant" in the child, we can notice the "child" in the adult, observing infantile feelings of rivalry, exclusion, envy, and anxiety relating to "not knowing" or feeling "small".* (Bradley and Emanuel, 2008, p5)

This is the somewhat more complex aspect for professionals and clinicians because of the very nature of the role meaning we need to convey and demonstrate proficiency and capacity to meet the needs in our children and families who come to us for assistance. We can often feel overwhelmed and/or out of our depth.

> *if we persevere and try to keep thinking, observe ourselves as well as our clients, and realise what is happening, we may find ourselves able to do more than we thought we could. Indeed, the better we understand what is being communicated to us, the more effective and interesting our work has a chance of being.* (Bradley and Emanuel, 2008, p135)

Sometimes, as with the parents, professionals can require support or intervention, a sense of containment, to achieve what is needed to be achieved with and for clients.

'Psychic Hooks and Bolts: psychoanalytic work with children under five and their families' by Maria Emilia Pozzi (2003) and 'What can the matter be? Therapeutic

interventions with parents, infants and young children' by Louise Emanual and Elizabeth Bradley (2008) are both helpful and accessible books about the theory and practice of work with under-fives.

Search results

Results from the literature searches are presented via three headings related to the focal questions, becoming shorthand for them: 'Anxiety' became shorthand for what professionals emotionally manage; 'Containment' represents what impacts professionals' provision; and 'Integration' encapsulates perceptions of inter-discipline/-agency working and outcomes for infants and families.

Anxiety

This collection of studies researched emotional reports from a number of different professional disciplines working with under-fives and their families.

A single case study by Dr Jones (2013) recorded her feelings when presented with clinical material from a supervisee working with a teenage mother. Jones stated:

> *I noticed how irritated I had come to feel …. my discomfort grew …. What was going on within me? …. I wanted to reject the material in a critical way. …. I felt judgmental* (p234)

Jones (2013) described internal conflict and uncomfortable countertransference. She pointed out variation between individual professionals, of evoked emotions. She demonstrated dialogue between herself and her supervisee, pertaining to emotions, served the good of the family. She stated that 'responsibility for the survival of a baby creates understandable tension' and highlights *'*conflicting wishes*'* amongst parent, family and network (p234). Jones cautioned:

> *The professionals involved were at risk of unwittingly feeling provoked into judgmental and rejecting responses* (p235).

As an empirical analysis of a professional's experience with clinical implications, this corroborates Alvarez's conviction regarding the importance of attending to one's feelings: 'transference and countertransference…. are the work's most vital instruments*'* (2012, p178).

An important aspect of work with under-fives according to psychoanalytic psychotherapists is the capacity to be able to notice and consider the different identifications within the dynamics of family relationships (Pozzi, 2003).

As a single qualitative case study, it is hard to know how Dr Jones' observations could be scaled-up clinically.

A larger-scale study by Alakortes et al (2017) involved Finnish Child Health Care Nurses (CHCNs) [and parents] across 26 municipal districts working with 1008 1-year old infants. CHCNs' role seemed comparable to that of NHS health visitors. Interpretative Phenomenological Analysis (IPA) was applied to the data. At recruitment, they stipulated their focus was child development and early interaction. They used worry or concern observational reports by CHCNs, background demographic questionnaires and a Brief Infant-Toddler Social and Emotional Assessment (BITSEA) screening tool. The title and goal of the study was *'*Do child healthcare professionals and parents recognise socio-emotional problems in 1-year old infants?'

Alakortes et al (2017) found professionals reported anxiety associated with having difficult conversations involving emotive and sensitive issues with parents, and experiencing differences of opinion with them. CHCNs claimed that parents under-reported their anxieties, and there was an implicit bias that professional opinion is dominant or correct. This gives a hierarchical sense indicating power-dynamics. It seems likely that professionals may also under- or over-report though this was not debated. Hood (2015) found working relationships are not straightforward in another study. He reported *'*complexity makes it hard for practitioners to understand cause and effect, predict outcomes and control the course of

events' (p140). These observations are, perhaps, representative of a lack of awareness of unconscious processes and/or insufficient identification with self-and-other positions and experiences.

Alakortes et al (2017) conveyed sensitivity regarding socio-emotional observations, explicitly stipulating their perceived need for a recruitment banner related to child development. They worried that transparency may have incited disturbing and/or stigmatising thoughts. It is possible they perpetuated the anxiety via projection and/or collusion.

Authors used an observational tool devised by them. It was not clear what the observation tool was and there was no mention of its validity. Researcher-designed tools can carry inherent bias and may compound findings.

Professionals clearly identified their felt anxiety but the study failed to explore how this might impact the work and/or working relationships with infants and parents. In comparison to Jones' single case study, it lacked her clinical relevance and application of countertransference.

Hood's (2015) study suggested the matter cannot be simplified into observations and/or assessment tools. He looked at professionals' understanding of complexity within a range of child care services. Complexity is a comparable benchmark for CAMHS and other child care services. He studied inter-professional working of a single complex child protection case. He deduced that 'we make sense of the world by employing cognitive and conceptual schema that are defined through our relations with others', presenting a highly complex internal picture of working relationships (p142).

Zeanah et al (2006) studied working relationships between 9 nurses and their patients. Participants had trained to deliver a medically oriented Nurse Family Partnership (NFP) programme supporting mothers and babies. This seemed akin to NHS health visitors. Nurses were divided into two groups: both groups were provided with an understanding of mental

health and associated psychosocial factors; and the focus group benefitted from ongoing access to specialist mental health consultations.

The aim was to understand whether those trained in a medical model could take on a psychosocial model and, whether cross-pollination of models might improve physical and mental health outcomes for mothers and babies. The programme used 'relationship-based interventions', and nurses were primed to re-frame their usual working relationships into 'therapeutic alliances' (p43).

Zeanah et al (2006) found variability amongst nurses' confidence in assessing mental health difficulties; a range of emotions reported; key differences between the control and focus groups; and effectiveness of the programme in preventing mental health difficulties later in a child's life.

It was not discussed whether variability in nurses' self-confidence to assess mental health difficulties could relate to newly acquired skills requiring more time to embed; or individual variation in learning capacity; or the over-riding medical discipline; or something else. It is possible nurses' novel experience may have individually stirred something, consciously or unconsciously. Further, it is possible conscious or unconscious experiences or preconceptions may have impinged assessment skills. Authors acknowledged they were not able to explore individual and personal lives in this study.

Anxiety reflected by nurses included:

> *sometimes just not feeling capable of handling some of the situations. Did I miss some subtle hints or some subtle happenings and waited until it kind of got worse and then I noticed it?* (p47)

This highlights responsibility, self-doubt and the emotional toll nurses felt. These were repeated reports.

Key differences between the control and focus groups were that the latter reported: feeling better able to deal 'with their own emotions that, at times, seemed overwhelming

when faced with the mothers' problems; that it was helpful to have 'access to other services'; and 'to have that body of support' referring to the mental health consultants (p48). Collaboration decreased stress levels according to nurses, providing reassurance, support and containment.

By contrast lack of collaboration for the control group was felt and interpreted as barriers, both to the nurses themselves and for the families they worked with. This nurse explained:

> *We feel that our clients get shorted because they don't have access to the mental health consultant". Some of the nurses suggested that the mental health issues of the mothers or their extended families influenced the clients such that they stopped participating in the program.* (p48)

It seems likely nurses also felt 'shorted' of something if one considered this projection. These findings raise potential grievances and/or resentments associated with a perception of deliberate and punitive withholding of something helpful. Such internal conflicts might impact nurses' capacity to work with difficult emotional scenarios. Such complexities were not discussed.

Zeanah et al (2006) noticed benefits of reflection provided by consultations:

> *personal and professional boundaries as well as transference and countertransference issues were frequently discussed in case conferences, during individual supervision with the supervisor, and when available, in consultation with the mental health consultant'* (p51).

The valuable resource of other professional minds offering reflection, containment and expertise, outside one's own field, is highlighted here. Rustin and Emanuel (2010) describe the value of clinical consultation with child psychotherapists, a health visitor received to the aid of a mother and 3-year-old. Interpretations of the child's behavioural communications and the psychoanalytic perspective of dyadic and triadic object relations enabled this health visitor to understand the child's experience and internal world and support the parents to resolve the problem (p90).

The emotional toll on nurses including some reported incidents of impact on their families was evident. Nurses described ‘helplessness’, ‘disappointment’, ‘guilt’, and one said, “it is hard to be mentally prepared, and ... to be able to let it go” (p49-50). The unpredictability of the work was raised too as this nurse explained ‘you never know what you are going to find or see, or what’s going on’ (p49).

One nurse recorded the extreme anxiety of disgust describing a home she visited as ‘filthy’ (p48). This singular account, perhaps, suggests disgust did not feature enough for it to become a theme. As a difficult anxiety to experience, its lack of attention may be linked to fear of judgment and prejudice. It seems both striking and unfortunate authors do not take this up.

Wheeler and McElvaney (2018) suggested the view of difficult emotions within work is one-sided. They investigated positive emotional impact on psychotherapists working with children traumatised by sexual abuse. The study was called ‘why would you want to do that work?’ and participants expressed awareness of reward and special connectivity in their work. The presence of this study suggests maybe a balm is needed to counterweight professional distress associated with work with distressed children and families. Both can be true of course.

Zeanah et al (2006) noted, ‘frustration with clients was no more evident than frustration with administrative work’ (p49). Neither clients nor administration were elaborated upon which seems disappointing. As before, perhaps issues did not feature significantly enough to warrant a theme. These matters were not the study focus but to mention them and not consider some account for them leaves something out. Perhaps frustration with clients and/or disgruntled practitioners comes into the arena of issues difficult to think about.

Notably, Zeanah et al (2006) found the combination of psychological and medical models appear to have longer-term improvement of the mental health of infants. This may be linked to sleeper effects as with some psychological interventions.

Another notable highlight was that cross-pollination of models did not corrupt or dilute the integrity of the nurses' role, as they saw it: 'experienced nurses did not view themselves as therapists, per se; rather, they seemed to retain their nurse-as-caregiver identity and were able to recognise their limitations and seek assistance when they were beyond their own capacity' (p51). This is noteworthy, given the investment in and distinction of professional trainings, institutions and bodies, and pride within multi-disciplines.

Zeanah et al's (2006) cohort admitted their study was small and posed difficulties for generalisability. They reflected whether introduction of relational elements into medical work meant subjectivity obfuscated objectivity; whether benefits of positive working-relations with patients/clients and measuring outcomes or meeting targets become blurred and/or ineffective.

Some boundary issues were observed as some nurses reported feeling like 'part of the family' (p51). This may pose challenges regarding what might be deemed professionalism. Zeanah et al (2006) hinted at subtleties and nuances in relationships, working and/or therapeutic, which could go unnoticed but then did not expand. Contextual attachments and systemic functions could be helpful to consider: for example, inter- and/or co-dependency.

One of psychoanalytic psychotherapist's key principles of observation can help the protection of the professional thinking mind and boundaries.

> *The therapist's use of observation provides a model of receptiveness, respect and tolerant curiosity. This attitude is combined with maintaining clear boundaries, seeking to explore the meaning of behaviour and putting things into words in a way which is understandable by both children and adults. Finally, the therapist's conviction that some change may be effected quite quickly if both children's and parents' anxieties are gathered in can be an important source of renewing hopefulness.* (Rustin and Emanuel, 2010, p91)

Observation does not mean being detached from an emotional experience but rather allows certain preparedness for an emotional experience and, flexibility and reflexivity. It goes hand-in-hand with acknowledging the likely need for consultation with other minds when exploring complexities of transference, projections and countertransference. Zeanah's nurses give the sense of being overwhelmed and not having the role of observer in mind.

Balbernie (2007) talked about 'intersubjectivity' which thinks about harnessing what happens between individuals as being part of therapeutic work. He was exemplifying the parent-infant relationship though it seems equally valid here. Zeanah et al's (2006) prevailing impression was that 'highly trained and experienced nurses, view forming strong relationships with their clients as critical to program impact '(p50-51).

The study vouched for candour amongst participants. One might wonder about the relationship between participation, candour and Zeanah et al's (2006) reimbursement. Reimbursements may impact participant motivation and/or commitment, positively or negatively.

The success of the NFP's intervention appeared linked to the therapeutic alliance incorporated into nurses' work and access to specialist mental health consultants.

The above studies signify the emotional experience of professionals in their work with distressed infants and families. Professionals are required to manage and contain anxiety, in its manifold guises, their own and that of the family unit.

Zeanah et al (2006) were alerted to the containment nurses experienced as a consequence of consultation access. Working relationships within organisational systems is the focus of the next section.

Containment

Containment is a recognised pseudo-parental function professionals provide infants and families. Therefore, it became shorthand for that which is provided by professionals. In turn, how professionals feel contained within an organisation/system, as the last study has shown, impacts their work. Whether or not, the term has been specifically applied by the following studies, they cite merits attributable to containment. Professionals' experience of containment can be seen to impact that which they provide to their clients.

O'Reilly et al (2010) conducted a study called 'Turning policy into practice', evaluating CAMHS in England. Members of government policy-making departments, CAMHS' higher education providers and diverse professional bodies represented within CAMHS, regional policy officers, and CAMHS' commissioners, managers and practitioners were interviewed. Forty-six stakeholders participated. O'Reilly et al's (2010) impetus was an NHS Health Advisory Service Review (1995) which 'demonstrated that CAMHS had developed in an ad-hoc fashion, lacked clear direction and investment plans were absent' (p506). Service crises often seem to result in cries for more money. O'Reilly stressed 'on its own, investment could not meet the requirements placed on the workforce' (p506). She considered what else might be going on. Perhaps this may be couched under the other familiar cry of work smarter.

O'Reilly et al (2010) considered some initiatives and evaluations which attempted to understand what would be needed to achieve quality service delivery with a quality workforce. They found one issue was 'the multidisciplinary nature of the service results in both advantages and disadvantages as professional qualifications and requirements differ significantly' (p507) and 'there is little agreement as to what constitutes a well-trained workforce, particularly given that the training of CAMHS staff is highly variable' (p508).

They suggested a gulf existed between governance and professional sensibilities which impacted on implementation and cohesion of mental health policy:

> *Our respondents explained these gaps by inferring that those staff who were trying to implement policy at governance and strategic levels had insufficient understanding of challenges at the operational level, therefore, of educational requirements.* (p515)

O'Reilly et al (2010) found insufficient connectivity impeding successful policy into practice implementation. Multiple disciplines and positions equated to multiplicity in perspectives and minds. The limitations were highlighted thus:

> *It is significant that there was limited consideration of how long training takes to make a difference to the workforce. Our experience is that, by the time effective training of good quality has been developed, the focus of policy may have shifted, and different service aspects may have become high-level targets.* (p521).

Re-interpretations of populations, community needs, changing targets and respective policy changes appear to make it nigh-on impossible to put into practice long-term strategic thinking or for evidence-based practice to be felt at a clinical level. O'Reilly (2010) helpfully pointed out inherent difficulties, differences and implications:

> *our respondents provided evidence of there being insufficient linkage between the governance, strategic, operational and clinical levels of policy. There was also evidence of opinion of insufficient understanding of the complementary roles played by staff at the different levels, or how lack of understanding at one level might influence the other levels systemically* (p520)

There seemed to be a lack of mentalisation, key in containment and for communication and understanding others' viewpoints and position (Fonagy & Allison, 2012)

The study is not without limitations which were acknowledged. There was not an even mix of multi-professionals. Results may have been different otherwise. O'Reilly et al (2010) defended interviewing participants by phone, leaning on studies claiming non-verbal language does not significantly impact participants' communications. It seems impossible to be certain how in-person interviews may have produced different findings in this context. It seemed somewhat reflective of the detachment in their findings.

Williams et al (2019) considered the quality of supervision as a containing function for professionals, having a more intimate reflective lens. They evaluated a training programme promoting a reflective style of supervision. They stated:

> *Reflective supervision differs from other models of clinical supervision in its emphasis on emotional responses of supervisee and supervisor, the parallel process occurring between the supervision relationship and the therapist-client relationship, and the encouragement of reflective practice that enables supervisees to arrive at their own conclusions rather than* [the supervisor] *directly advising or teaching (Shea, Goldberg, & Weatherston, 2016).* (p159)

Reported benefits include reduction of stress, increased insight and productivity of professionals, and increased successful treatment outcomes. Williams et al (2019) believed there was little research exploring the impact of reflective supervision on clinicians.

This research was conducted in California and the team comprised clinical psychologists: all female, with advanced postdoctoral qualifications in infant and early childhood mental health, and reflective supervision. All, save one, were involved in designing and developing the supervision programme. One team member, not known to participants, led the focus groups. The whole team were responsible for designing focus group questions and the coding manual.

Researchers used purposeful sampling to engage participants from 'publicly funded mental health agencies and supervised mental health clinicians working with children ages birth to five years' (p162) to train in reflective supervision. Williams et al's (2019) sample comprised 34 mental health supervisors from 26 different agencies.

Participants included 18 marriage and family therapists, 9 clinical social workers and 7 psychologists who were already providing supervision for licensed psychotherapists, unlicensed masters/doctoral-level psychotherapists, trainee psychotherapists and case managers. There were 4 reflective supervision groups of 8 members each, who met 8 times, for 2 hours, over 4 months. Participants were encouraged to discuss cases which felt particularly challenging, posed dilemmas and/or where progress was experienced. Following

training completion, participants were encouraged to join one of four focus groups. These groups were approximately 2 hours and audiotaped. Participants completed pre- and post-training evaluation forms, and 3 months post-study completed evaluation surveys regarding impact, if any, on their practice.

Williams et al (2019) described core merits of a reflective stance: professionals felt valued and valuable; creation of a culture of mutual respect amongst colleagues, staff and clients; provision of a sense of safety in the workplace, in therapy rooms with clients and in supervision; and a sense of belonging.

One participant supervisor said of their supervisee:

> *And if they're feeling good and safe and taken care of and respected and valued… it's my hope… that's what the clients are going to experience with them.* (p169)

Small-group supervisions were found to be 'a uniquely valuable aspect of the training model' (p170):

> *The composition of the groups was described as important to learning, including both homogenous elements (all members being supervisors, all in similar context of community mental health agencies with early childhood mental health programs) and heterogenous aspects (learning from people from different agencies). The group discussions included opportunities to learn from others "outside of my agency culture," and to consider alternative ways of managing common supervisory dilemmas*. (Williams et al, 2019, p170)

Participants conveyed benefits of experiential learning and learning in the safety of reflective and containing relationships; including reminders to include elements into practice; revisiting framework and principles; and helping to hold the reflective frame. This suggests the value in refreshers and ongoing containment. It demonstrates work environments have potential to pull professionals out of shape.

For some, reflective supervision was a profound experience:

> *As one member put it, "Can we meet forever?" In fact, one small group noted that they had arranged to continue meeting on their own after the formal training had ended*. (p170)

This perhaps indicates the relief of shared responsibility and/or camaraderie. Scepticism might equally notice potential for inter-/co-dependency and abdication of responsibility which might provide some relief in less healthy relationships. This potential cannot be ruled out. Containment appears simple in principle and is more complex in practice.

One participant showed how it is not easy maintaining a reflective stance with supervisees:

> *I felt myself wanting to say, "No, do this. You're going to need this." But I was able to intentionally just sit with it, let her go through the process, let her find whatever way she needs to go…. For me, that is really difficult still. It's still a process but it's a strategy I think I can continually use that I didn't have before.* (Williams et al, 2019, p171)

This demonstrates complexities within supervisory containment. It is possible to be intrusive, controlling and/or over-bearing. This does not necessarily indicate disrespect or un-care in this case but likely anxiety for good outcomes.

Williams et al (2019) added the approach is not limited to supervision, identifying opportunities for learning and sharing with agencies and disciplines outside of one's own 'agency culture' too (p170). This echoes already mentioned benefits within cross-pollination of models, ideas and thinking.

Supervisors noted benefits as 'this approach to supervision helped them to attend to the needs of their supervisees in a way that promoted their growth as clinicians' (p171). Dividends were multi-directional.

Rustin (1998) espouses the benefits of supervision as threefold: firstly, the knock-on or ripple effect of containment being passed through supervisor to therapist to client to infant/child; helping the therapist think when they are overwhelmed; and helping to make sense of material.

Williams et al (2019) findings reported clinical application. Participants shared:

> *feeling more effective, confident, positive, flexible, and empathic. Some noted being more "productive", "reinvigorated," or "energized." Taking a more reflective stance to supervision led to changes in the way one participant approached her work overall.* (p171)

The study indicated participants who experienced containment felt more effective in their role.

Williams et al (2019) included perceived barriers to implementing reflective supervision. They found work and productivity demands created a culture at odds with the value of reflection: quantitative over qualitative. They highlighted difficulty in shifting work/organisational cultures. Even when higher management were aware of the theoretical value of reflective supervision, there were 'challenges that occurred when these key individuals did not "buy in" or value its practice' (p174).

Participants shared a sense of isolation at work and in productivity, and difficulty in conveying learning and onward training, once out of the project-bubble. They perceived this as a barrier to implementing reflective supervision in practice.

> *Isolation is probably going to be the biggest threat* [to implementation]. *If you are the lone wolf in your agency or in your system and now the project is over, where are you going to get your support?" Another shared, "it's very everybody to themselves, it's very easy to become isolated."* (p174)

On the one hand the study raised the idea of united-ness and team-/culture-building, and on the other the concept of dividedness and isolation.

Williams et al (2019) talked about the generalisability of their study. However, feedback regarding the impact on supervisor's practice and implementation was varied. Views ranged from impactful and meaningful engagement within a reflective culture to agency culture and isolation making it difficult to implement a reflective containing approach. More would need to be investigated regarding the variations.

The study recognised bias in their researcher-designed programme yet claimed openness to expose themselves to positive and negative feedback as mitigation. The openness

to criticism however focuses on barriers to implementation, rather than reporting criticisms of the programme itself. More convincing was consistent evidence of participants' learning outcomes cross-referenced with recognised reflective supervision core values.

Williams et al's (2019) study is relevant because participants were from public sector organisations, covered a range of disciplines and worked in infant mental health. The study did not mention demographics but one might assume they are broadly comparable data.

The concept of supervision and containment for professionals is not novel. Michael and Enid Balint created reflective discussion groups for doctors in post-war 1950s London (Salinsky, 2009). O'Neill et al (2016) used Shoenberg and Yakeley's (2014) UK University College London (UCL) Balint group study to springboard their own study 'The Balint group experience for medical students: a pilot project'. They cited renowned significant loss of empathy amongst progressing medical students as their study driver.

O'Neill et al (2016) informed 'ironically, the current, well-intentioned crusade for evidence-based medicine, coupled with rapid advances in medical science and technology, may have exacerbated the problem by distracting students from the need for an empathic encounter with every patient' (p2). Employing Balint groups was hoped to understand this.

This study met selection because empathy is integral to work with infants/families and containment. It is relevant to consider practices which potentially enhance or dilute empathy.

Traditionally, Balint groups offer a supportive, non-judgemental context for candid discussion of the emotional aspects of illness for patient and medic including contemplating potential prejudice and/or preconceptions of patients. Meeting regularly, group goals included development of empathy, compassion and clinical communication skills.

O'Neill et al's (2016) pilot study was conducted in Sydney, Australia. Six third-year students were recruited into 6 Balint meetings over a 6 month period. Students completed pre- and post-questionnaires based on attitudes towards student-patient relationships and

expectations of the Balint group. All students wrote a 1000-word reflective essay based on one case study discussed in the group.

O'Neill et al (2016) found the need to adapt group concepts due to students being unaccustomed to thinking in emotional, social and psychological ways about their patients. They said:

> *For example, they struggled to consider psychological/emotional issues when a patient presented with acute symptoms, believing that their focus should be entirely on 'solving' the medical issue.* (p5)

They reflected this was because their participants had had little exposure to patients until this, their third-year of training. This expansion of conceptual thinking seemed akin to the cross-pollination of ideas expected in Zeanah et al's (2006) study.

O'Neill et al (2016) found:

> *Following the students' feedback, the leaders realised that they needed to adapt the method to help contain some of these anxieties, by making supportive interventions designed to ensure that the students were better able to feel held by the leaders.* (p5)

This adaptation is noteworthy because it highlights that participation may not be interpreted as comprehension of the task or function of an activity. This finding is relevant because it identifies a potential difficulty within multiple disciplines with different perspectives communicating in different languages.

O'Neill et al (2019) commented students often reverted to their 'familiar' medical model (p6). This demonstrates the challenge involved in shifting paradigms and culture. Also:

> *Even though these students were strongly predisposed to benefit from the sessions, it was clear that they sometimes had trouble getting to the sessions on time and 'switching off' from the pressures of their day's work. Time was needed to allow them to move into the more reflective mode of the group sessions.* (p6)

There are likely parallels with the rigours of everyday work in children's health and social care services and CAMHS. O'Neill et al's (2016) participants were students in the throes of intensive and demanding training so the study is not straightforwardly comparable.

O'Neill et al's (2016) findings were as they had hypothesised. Students 'felt more alert to the impact of their own humanity and personality on the patient, confirming…. a Balint-style approach can help students recognise and understand the emotions they bring to an encounter with a patient' (p9).

One of the purposes of the Balint group was to confront prejudices and consider preconceptions. O'Neill et al (2016) presented findings from the reflective essays which revealed 'cynicism, insensitivity and even a certain callousness' (p8). Judgements located in race, ethnicity and lifestyle were exposed. One participant said:

> *It was not the initial presentation of her in hospital that really bothered me; she was a young lady that fit my stereotype of a drug addict; the faces of drug abuse and the crazy hair made her fit my mould of a patient who might be involved in drug use.* (p8)

Students appeared to discover hidden unconscious prejudices and projections.

Crehan and Rustin (2018) suggest 'epistemic anxiety may be evoked by learning that threatens existential security and a stable sense of identity' (p72); an 'anxiety about what might be revealed about the self and its unconscious beliefs, emotions and phantasies' (p82). They consider work discussion groups as prime arenas for challenging inherent, internal and frequently unconscious prejudices. Courage is required to reflect honestly.

O'Neill et al's Balint groups appeared to provide, not only safe, but valuable and necessary spaces for these issues to be reflected upon. Students felt they benefitted from the reflective and explorative opportunities.

Student reflections included reservations about system difficulties and flaws. O'Neill et al (2016) described this occurring as student awareness developed. Students became critical of a lack of sensitivity for patients' dignity and respect, and lack of time for personal and emotional issues by and within the organisation. Students blamed work throughput demands contributing to trust in patient care being eroded. Local authority and NHS workload demands seemed equable with the students' experience of throughput.

Overall O'Neill et al's (2016) findings suggested students found reflective space beneficial as a resource once they understood how to use it and it was tailored to meet their needs.

Trials in Gloucestershire Child-in-Care CAMHS appear to corroborate above studies. Small supervision groups for social workers facilitated by child psychotherapists are being trialled. Early findings have demonstrated the value of supervision for social workers exemplified by a valued sense of support; space for emotional outpourings and containment; benefits of shared reflection and thinking. The trial is a pre-emptive evaluation study as yet not published (Personal communication, 2020).

The above studies noted benefits of connectivity and containment as well as raising complexities. Implications associated with organisational functionality raised by some study participants above in different ways follows in the next studies.

Integration

The literature search uncovered studies reporting on relationships between professionals and/or agencies impacting professional/service functionality relating to the third focal question. Integration encapsulates the way professionals express perceptions of inter-discipline/-agency working together, including dissemination and/or assimilation of training, information and/or intervention tools.

Coe et al (2003) studied 'services for pre-school children with behaviour problems in a Midlands city' by conducting a survey of services.

> *The survey aimed to identify all service providers in the city and collect data related to service provision, inter-provider co-ordination and co-operation, to inform the development of a comprehensive pre-school behaviour service co-ordinated across agencies using programmes with a strong evidence-base*. (p418)

Coe et al (2003) found: evidence of key staff working, without adequate training or preparation, delivering evidence-based interventions; variations in delivery of evidence-based

interventions inasmuch as they were manipulated and/or deviated from depending on the professional/team utilising them; and little coordination between different agencies despite there being knowledge of other resources and services which might be beneficial to children and families.

Health visitors (HV) were targeted via presentations. Fifty-nine questionnaires yielded 39 returns, a 66% response. Questions included interventions used, referral practice and constraints to practice. It was reported HVs work closely with nursery workers and provide behaviour management interventions with parents city-wide. Results showed, although HVs deliver direct advice and support to parents, they believed their main role was to identify problems and refer onto other providers. In the preceding year, 90% had referred to nursery workers. Other referrals included social care, community paediatricians and, in the minority of cases hospital paediatricians. It was notable that referrals to CAMHS were absent from the summary list.

Perceived barriers to inter-agency collaboration and/or referring were reported thus:

- *inability to refer directly to Child and Adolescent Mental Health Services (CAMHS) – 33%;*
- *long waiting lists for other service providers particularly CAMHS, nursery nurses and behaviour management groups – 38%;*
- *inconvenient location of behaviour management courses – 15%;*
- *lack of information on available services and 'what works' – 10%*

(p419)

This constituted phase 1 of Coe et al's (2003) study. Phase 2 conducted face-to-face semi-structured interviews with nursery nurses and other lead providers. Fifteen nursery nurses, 3 community paediatricians, 1 CAMHS' consultant psychologist, 5 education providers, 4 service managers and 8 voluntary sector providers participated. Thematic analysis was used for notes taken at the time of interviews.

Coe et al (2003) found major themes: knowledge of local providers, e.g. a high proportion of participants, two-thirds, reported knowledge of other services in their locality;

quality of coordination amongst providers, e.g. only a third referred to close links though none mentioned referral pathways; recognised referral exclusion criteria, e.g. 'most providers imposed age and geographical limits on referrals' and 'three nursery nurses mentioned complexity as an exclusion criteria'; and intervention programme models and materials used, e.g. '69% identified evidence-based programmes' being used (p420).

More minor themes included failed attempts and/or logistical difficulties to run programmes; the sense or lack of support in nursery nurses' role, e.g. 'five out of 15 nursery nurses reported feeling unsupported and three out of 15 reported that they had had no special training in behaviour management techniques' (p420-421). It is worrying nursery nurses felt this way when a high proportion of direct interventions are referred to them. This was not explored by Coe et al (2003). Funding issues and year-on-year changes meaning uncertainty of funding were also cited as minor themes.

Quantitative comparisons were used to validate themes. Coe et al's (2003) small numbers of provider groups made this difficult. However they believed material substantiated their themes. It seemed striking no participants referred to inter-agency access pathways, whilst identifying some inter-agency barriers. Coe et al (2003) suggested that generalised omission indicated protocol was not in place to comment on, therefore they did not challenge it. This seems unlikely as generally access to services is something given a great deal of thought by commissioners/policy-makers/managers. Alternative possibilities for omission could be the question structure/content, or a sense that implicit knowledge need not be expressed, and/or unconscious frustrations being difficult to express.

Mention of the 'failed attempt to run behaviour management groups and logistic difficulties' (p421) warrants more investigations as it was not discussed. Demographics were not mentioned by the study either. As many cities are multi-cultural by nature, might failure to operate certain interventions be related to services not being sufficiently inclusive?

Coe et al (2003) found nursery nurses, identifying referrals for other providers/services, were reliant on going through HVs. This could be really important to understand. For example, what impact does implicit and/or unchallenged hierarchy, and/or splitting between professionals, have on professional-identity, morale and/or service delivery? This was not taken up by the study.

The finding that evidence-based interventions are being deviated from and modified, despite rigours and validity, seemed important. Whether variations were due to personality, discipline, logistics or time-factors were unclear. It would seem that this makes quantifying success difficult. One might imagine there is sufficient congruence, amongst practitioners, otherwise evidence-based validation would prove irrelevant.

Variations might be linked with their other finding regarding some providers feeling ill-equipped or un-trained to deliver interventions. Lack of adequate training and/or updates would understandably lead to implementation variation. The link was not considered by researchers. Perhaps variation was too insignificant for discussion. Nevertheless, there is something which psychoanalytically suggests a lack of connectivity or integration expressed by some participants.

Coe et al (2003) recognised that parenting takes place within a social, political and economic context. These factors influence parenting styles, practices and feelings. Fraiberg et al (1975) demonstrated the presence of intergenerational influences. It cannot be overlooked that professionals do not exist within a vacuum and are subject to such factors also. For example, O'Neill et al's (2016) findings of internal prejudices and preconceptions. Individual and societal idiosyncrasies suggest that relational ways of thinking about these issues might be helpful as Williams et al's (2019) study found.

Coe et al (2003) speculated that professionals and agencies may benefit from more integrated or joined-up ways of working. They stated they were unable to evidence this yet

suggested historical operational precedence as an impediment to integration and connectivity. This suggests organisations are not flexible enough and/or have difficulty accommodating changes/updates. They also cite pressure to address problem behaviours in adolescents which detract from the importance of early intervention resulting in a distraction from infant-up fully integrated services.

Davidson et al (2012) conducted an initiative to improve interface-working between mental health and social care via evaluation of a single case study. Their study took place in Northern Ireland's Health and Personal Social Services within Northern Health and Social Care Trust (NHSCT). Services comprise separate mental health and child social care directorates within the same organisation. Davidson et al (2012) hypothesised being of one organisation does not necessarily mean better integration and collaboration between professionals; and that the medical model can often dominate within integrated services which might impinge working collaboratively.

Davidson et al (2012) were motivated by reports of parental mental health difficulties, directly and indirectly, impacting children and families with some cases requiring safeguarding intervention. Direct impacts included children having mental health difficulties of their own and indirect impacts included socio-economic deprivation. They emphasised that the majority of parents with mental health difficulties parent their children appropriately and do not come to the attention of children's social care or raise safeguarding concerns.

The Social Care Institute of Excellence (SCIE) issued a comprehensive guide entitled 'Think Child, Think Parent, Think Family' (SCIE, 2009) which influenced the NHSCT. A recommendation was to have Champions at management level in each service to facilitate interface-working. The NHSCT introduced champions at front-line level in response. As part of a first phase Champions were identified from social work staff only. Other staff could apply via a formal interview process. Davidson et al (2012) used this base-line opportunity to

evaluate the new role to gather novel data and follow-up six months after role uptake. Davidson et al's (2012) evaluation team came from child care, social work training and education, and mental health disciplines.

Questionnaires designed by Davidson et al (2012) sought quantitative data from 24 Champions (12 from mental health and 12 from child care) plus 59 mental health and 26 child care team members. Questionnaires included open questions to elicit experiences associated with barriers and/or improving interface activities. Some differences in questionnaires were required due to role-specific areas of mental health and child care practice. The six-month follow-up questionnaires sought qualitative information from Champions and respective team managers regarding role and impact.

One hundred and nine questionnaires were completed at the baseline phase. Eighty-four per cent were women. Of the 109 staff 94% had attended relevant training provided by Area Child Protection Committees (ACPC), 72% completed training via NHSCT's regional assessment framework based on children's need, and 73% completed 'recognising and responding to child abuse and neglect' (p164). Only 42% attended a relevant course in child protection and mental health.

In the final phase, 71% of Champions and 38% of team leaders completed questionnaires. Team member baselines were compared to ascertain if there were any defining characteristics of the Champions which stood them apart from the team or each other. No significant differences were cited, aside from Champions having slightly more pre-qualifying experience than other team members. All child care Champions were social workers with social care backgrounds and, of Champions from mental health teams 48% came from social care and 34% came from nursing. Mental health team Champions had been qualified for an average of 13 years in contrast to child care team equivalents average of 6 years. No statistical analysis was provided to verify significance or otherwise of this data.

Teams were asked to identify how many cases involved parental mental health and, of these, how many involved both mental health and child care teams. Mental health staff identified these as 8% and 4% respectively, and child care 38% and 23% respectively. Davidson et al (2012) felt figures seemed low and wondered if questionnaire language led to variable interpretation or understanding. For example, the word 'issue' could trigger different levels of concern for different individuals. Sixty-four per cent of mental health staff and 50% of child care staff reported attending interface meetings where mental health and child care met.

When analysing barriers reported in qualitative comments, Davidson et al (2012) found:

> *The main themes that emerged about difficulties with the interface were: communication; confidentiality; differing priorities; continuity; and confidence.* (p165)

Champions' sense that something regarded as an issue by one team was dismissed as nothing by another was cited under communication difficulties. Perhaps this reiterates the point made about discipline language differences. Other communication difficulties included different database systems; frustrations regarding others not responding to messages or calls, and not being available; and feeling as though one is left holding things beyond one's remit, e.g. mental health staff managing child care issues. Comments of this nature were written as though they denoted fault or blame located in the other. This was not commented on.

Regarding differing priorities, some Champions cited that child care held the child as paramount and for mental health adult confidentiality was priority. Such a source of conflict was not elaborated on. Child care reported more difficulty with staff retention than mental health counterparts: 'turnover of child care staff being a major difficulty*'* (p166). Arguably this is a perennial issue recognised by UK local authority and the NHS. Davidson et al (2012) did not clarify how this might be related to or impact the sense of integration.

Regarding the confidence theme, this was closely allied with a perception of an interface training and skills deficit. This complaint mainly came from mental health staff who stated traditionally this sort of work was undertaken by social workers and community mental health personnel. Mental health staff stated that more recent times had seen them asked to take on more generic aspects of the work. Perhaps these comments represent professional identity grievances, a sense of specialist skills being lost and/or diluted, and/or identity boundaries/differences becoming blurred. This was not explored in the study.

Regarding issues of continuity which might improve interfacing, Davidson et al (2012) noted the following: 'getting to know each other; communication; training; knowledge; and resources' (p166). Findings seemed focused on increasing understanding of the others' role, in a way which suggested other had been somewhat alien. Joint training and training to reconcile different perspectives were among suggestions: 'Shadowing' others and work 'exchanges' for an appreciation of the other, for example (p166). A common wish for more understanding, collaboration and integration seemed to convey a desire to be known and know others. There was inconsistency regarding how this could be achieved. Perhaps this is because whilst there are perceived benefits to shared-learning but this misses the point regarding professional identity which was not taken up.

More resources were a common call from all participants. This affirms O'Reilly et al's (2010) observation.

Different database systems were identified as a frustration of interface communications. The study stated it was difficult to understand why there was no consensus with databases. In other situations where teams are not integrated under a united organisation, then political and/or financial issues likely impede cross-agency budgeting. Nevertheless the point stands regarding it being a frustrating barrier for those working within the field.

Findings involved assessment forms which complained that child care forms routinely prompt thoughts about mental health but adult mental health do not routinely prompt about child care. Davidson et al (2012) said, at the time of their study, adult mental health care documentation in England and Wales did include a question alerting professionals to familial children. They argue the perception regarding its absence suggested it was insufficient. This perhaps raises the point, again, regarding discipline language and semantics: child care and an alert about children are different things. Assessment tools need to be specific. However this would seem a relatively simple fix to improve inter-agency working.

There were repeated comments regarding the value of inter-team meetings providing opportunities to discuss dilemmas and cases and increase understanding of different approaches and priorities. Such opportunities would pose time-poor and work-heavy agencies a dilemma.

At the six-month follow-up phase Champions and managers were asked to detail interface activities and assess for obstacles, impact and/or development potential. Champions commented on increases in a consultative role, attending meetings and training, disseminating information to staff; some pressure to take on more complex cases rather than offering advice/consultation; raised expectations from team members regarding expertise and advice capacities; and having difficulty managing additional tasks on top of pre-existing demands. They found scope for improved knowledge, discussion, confidence and communication, and suggested developments such as:

> *the development of a mental health equivalent of the Recognising and Responding to Child Abuse and Neglect course; the opportunity to review dilemmas and issues that had arisen; protection of the time needed to develop the role; extending the initiative across all teams; and the introduction of standards for interface working.* (p167)

Team leaders' views concurred with much of the Champions'. They added Champions as individuals had been impacted upon, noting an 'enthusiastic and positive impact on motivation' (p167). Davidson et al (2012) called this a 'happy side-effect' (p169).

They suggested continuing initiatives for staff to get to know each other including whole team visits, discussions sharing practice and creation of a resource pack about different teams. They also felt it important for Champions to meet regularly as a group for peer supervision.

Davidson et al (2012) were confident that they established the idea of having someone in one's own team who is responsible and accessible, to aid interface working with other teams and services seemed beneficial. They confirmed that their findings concurred with the SCIE (2009) report. Potential risks include raised expectations or assumptions Champions experienced: ideas that they carry additional expertise. It possibly suggests the team assumed less shared responsibility and/or abdicated some. Champions felt this as pressure. However this was relatively easily resolved by managers ensuring clarity of role and the creation of peer support groups.

It is positive that additional resources seemed to be kept to a minimum by using existing staff as Champions. Investment would be required nevertheless to protect an allowance of time for Champions to be effective and not compromise existing workload demands. Participants demonstrated capacity to generate achievable proposals for development and improvement which is another asset. The need for creation of this dedicated role suggested collaborative or integrative working is challenging otherwise.

There would be ongoing maintenance for Champion roles which could present as time-consuming in practice: shadowing and exchanges would need repeating regularly, not least of all to account for staff turnover/changes. The study suggested dividends would be worth the investment and could constitute continuing professional development.

Initiative participants wanted to see Interface Champions expanded in multiple teams. This would require strategic cooperation and some financial investment to dedicate time and training needed.

Davidson et al (2012) recognised there were some limitations to their study. Champions across a broader range of disciplines may have produced different outcomes.

They mentioned a dominance of medical models. As this was not expanded upon it is not clear how this related to findings, if at all.

Champions reported on training as one of their activities. It was not clear what this referred to: the new Champion role or other generic training. Davidson et al (2012) did not repeat the quantitative questionnaires at the six-month end phase. Had they done so, aspects of quantitative learning may have been highlighted, e.g. pertinent training.

Self-designed questionnaires present bias which, even with a multi-disciplined evaluation team, is difficult to mitigate. Perhaps Davidson et al's (2012) interest in barriers/obstacles, positives and successes demonstrated a mitigation attempt.

It was not clear why team leader opinions were not gathered at baseline. Other factors may have been discovered.

Davidson et al (2012) used external researchers at data collection and anonymity processes but this may not have entirely mitigated the bias that the majority of Champions, staff members and teams were known. It is possible that certain characteristics may have stood out, e.g. speech/language idiosyncrasies and/or colloquialisms might have revealed identities.

Davidson et al (2012) informed of the removal of medical caseloads when making comparisons between child care and mental health teams. They believed otherwise this would skew child care and mental health comparisons. They mentioned the difference between average numbers of cases in the mental health versus child care teams being 37 and 13 respectively. The low percentage of child care and mental health case involvement was mentioned as a surprise. As none of these points were expanded upon they leave some confusion.

Collegial relationships are complex. Bion (1961) wrote about group relations including work groups and unconscious forces manifesting in regression, assumptions, splitting, struggles for omnipotence and so on.

Champions had a sense that referrals increased as a result of their activities. Commissioners/policy-makers/managers may have concerns about budgets and resources; Professionals might be concerned about additional workload. There are all sorts of agenda at play and inter-relations are not straightforward.

Complexities present opportunities for resistance and/or aversion to change. The historical impediment Coe et al (2003) referred to is perhaps linked to individuals' preference for the familiar, even if known mechanisms have proven ineffective and evidence-based effective alternatives present with accessible opportunities for growth and development. Davidson et al (2012) did not explore these aspects. Freud (1914) exemplifies difficulties within changing familiar ways in 'Remembering, Repeating and Working-through'. Britton (1998) used Kuhn,1962, to describe how new paradigms are difficult to introduce and/or be taken up due to inherent anxiety regarding de-integration of old ways of doing things, the destabilisation this brings and the uncertainty of the new. Despite a desire for better integrated services, whether multi-disciplines in one organisation or separate specialist services, integration and/or integration of something new/different takes time.

Summary

The process of the narrative literature review posed many challenges as mentioned. Nevertheless the outcome has resulted in research findings pertinent to the principle questions.

Under Anxiety research showed professionals manage a great deal of varied emotions in the nature of their roles. It was noticeable in these selections that given an opportunity,

professionals openly shared some of the difficult feelings they carried. Psychoanalytic psychotherapy offers a way to reflect on these feelings and consider countertransference as an asset to working relations.

Secondly, Containment studies exemplified the value professionals gained from having a regular space for reflection in the form of supervision, consultation and/or Balint groups. Participants valued reflection and containment which showed dividends for themselves and their role. Containment gave space to have a safe space to vent and explore difficult feelings, consider preconceptions and have multiple minds thinking together. A pertinent point, made by one of the CHCNs, was the importance of retaining one's professional identity at the same time as benefitting from the support: containment was experienced as an additional asset to her own skills. Psychoanalytically these are important nuances: how does one join, connect and/or benefit from what others may provide whilst at the same time not losing one's individuality and an aspect of self-containment.

The previous comment has some links with the third collection of studies under Integration. The idea of connectedness and integration with colleagues and/or other agencies appears associated with better functionality, though there are disagreements as to what form integration might take. A variety of professionals raised important ideas around communications, shared learning, conflicting priorities, all of which can hinder and/or enhance working relations. Studies raised pragmatic and/or practical ideas to improve efficiency, communication and integration. However findings seemed to overlook internal unconscious psychic influences and contributions which play a role in interpersonal and working relationships. Examples could include internal concepts of identity, dependence-independence, reliance on others, self-and-other, rivalry, envy, jealousy, competition, and so on. Such complexities are of interest to psychoanalytic psychotherapists and systemic practitioners.

Aside from Dr Jones' voice there was an absence of psychoanalytic research in the domain of the search. Single case studies regarding the therapist's experience are not lacking within psychoanalytic research. The studies selected for review identified literature involving multiple participants, of like-disciplines and/or teams, and scrutiny of collectives. This suited the quest of this study being that populations of professionals and under-fives are under scrutiny. Other studies would likely have bought other aspects or issues to light resulting in other different and unique narrative reviews. Notwithstanding the studies selected have brought meaningful issues to attention, stimulated thinking and informed direction.

Chapter 3: Project Design

This is a small qualitative study undertaken with a range of multi-disciplinary professionals working in infant mental health and/or under-fives health and wellbeing services. I will describe evolution and aims, participants, ethical considerations, analytic method choice culminating in my design.

Evolution and aims of my study

Following the realisation of discrepancies regarding how under-fives do, or do not, come to the attention of CAMHS my lens moved from parents-and-infants to professionals-and-services. There seemed something difficult to communicate, understand and/or think about with my colleagues which I needed to understand. Existing research did not seem to quite satisfy what I was trying to grapple with.

Holding onto psychoanalytic psychotherapy principles I sought meaning within this experience and within relationships between professionals, services and under-fives. It seemed difficult to imagine developing meaningful dialogue with internal or external agency colleagues regarding the psychoanalytic perspective of the child's experience if we could not understand each other. Dialogue seemed important if one is part of a system hoping to meaningfully impact under-fives and families. The biblical Tower of Babel provides powerful imagery regarding an inability to communicate and benefit from rich difference and diversity (Genesis chap11, vs1–9).

Therefore, I arrived at my question regarding what child psychotherapists need to understand in their role working with under-fives in a mental health service. I hope to try to understand the place of infants/under-fives in the minds of professionals through the narratives they tell of their emotional and lived experiences. My aims are that findings will enlighten me, other child psychotherapists and other disciplines about work with under-fives,

how we may better understand each other and improve inter-discipline/-agency working in the interests of infant mental health and wellbeing.

Participants

Participants constituted 15 experienced professionals across a range of children's services. They came from children's social, medical and mental health care with a mix of front-line clinicians, managers and commissioners. The diversity meant I hoped to gather experiences from direct and indirect providers serving under-fives. Participants who came forward were from within the following disciplines:

- Psychology
- Health visiting
- Child and adolescent psychotherapy
- Service management
- Care commissioning
- Paediatrics
- Mental health
- Psychiatry
- Child nursing

Participants included 2 male and 13 female professionals. The majority of participants were white British and were not asked to share age or ethnicity details. Seven of the fifteen participants were CAMHS' colleagues.

Invitation to participate also included the following service areas:

- Early Help
- General practitioners
- Social Care

- Under-fives' taskforce
- Parent Infant Partnership organisation
- Inclusion and Family Services
- Educational Psychologist
- Children's safeguarding
- Children/Family centres

No one came forward from these sectors. It is curious as to why this was the case. Perhaps there is something about conceivably closer working relationships amongst mental health practitioners and services; perhaps invitees who were less directly or in-directly aware of me, as a professional, felt able to ignore another pressure in their busy/full diaries and those with direct/indirect association felt less able to refuse my invitation; perhaps the non-participants sectors have a more global way of working with families and less close encounters with infants or parent-infant relations; perhaps because less is understood, via training provided for social, education and/or general medicine practitioners, about the significance of infants' experience and early inter-relations; perhaps it was because of something else.

Practical and pragmatic limitations of this doctoral study meant it was not possible to spend more time recruiting more diversity and analysis of fifteen interviews pushed this project to the limit.

A range of professionals was important for several reasons: to counter my natural bias; to reflect professional tapestry from commissioning provisions to service delivery; to understand whether different roles perceive and/or experience under-fives differently; and to consider how under-fives and families might be expected to travel through different services, or multi-professionals/-agencies achieve meeting the needs of under-fives and families.

I recruited participants through different methods. I emailed invitations including the study summary and factsheet to professionals: some known; some known by name but not previously worked with; and others I found roles/names where previously unknown in any capacity. Follow-up emails and/or phone calls were made to those who responded. Some colleagues I approached directly and, if they agreed to participate, I emailed/gave them summaries and factsheets as a follow-up. Some professionals were suggested to me by word-of-mouth.

I surmised that whether there were prior collegial relationships or unbeknownst there were likely to have been different reasons for participation consent. Public facing documents (PFDs) were used to introduce and explain my study and recruit can be found in the appendices (Appendix III)

Ethical considerations

I considered a range of ethical dilemmas pertaining to perceived and unintended risk. Known risks included protecting against information of a personal nature from coming into the public domain. There was potential for this to occur via interview material, directly if details of under-fives and families were revealed in experience examples or, indirectly via others were able to deduce identities by geographical or personal signifiers. Therefore, it was important to convey interviews and data would be confidential and anonymised as measures to resolve these issues.

It was important for participants to know I would be both interviewer and researcher. Often there is an attempt for these to be different individuals but this was not possible in my situation. This involved confidence in professional ethics and a process of accountability. Clear routes for recourse if any breach were felt to have occurred were explained.

Unintended risk included not knowing how interviews might trigger or stir emotional states which subsequently professionals might need support or debriefing for. To prepare for this eventuality I made candidates aware beforehand via PFDs and conversation, and by providing signposting to a support service if it were required.

Ethical considerations were ongoing and not limited to the process of approval. Being a small-scale local study participants knew me, knew other participants and/or had working relationships with each other. It is possible such connections influenced interview material by potentially freeing up and/or inhibiting candour. This was an unavoidable yet within the bounds of tolerable ethical conflict due to limitations of the doctoral study.

Another dilemma became apparent during writing-up. To maintain confidentiality and anonymity for participants, I realised I would be unable to identify individual professions in the course of using the data material. This has been frustrating because part of my interest was to consider different professional perspectives. Certain CAMHS' data has been included because of being under the auspices of CAMHS and the significance of some issues raised about CAMHS and inter-agency working. I am confident that participant identity can remain confidential.

The ethical approval process was relatively straightforward. I used the Health Research Authority (HRA) online tool. This affirmed, as participants were not deemed vulnerable it was not necessary to go through the Integrated Research Application System (IRAS). Rather, I obtained necessary NHS Trust Research and Development (R&D) department approval, followed by Tavistock and Portman Trust Research Ethics Committee (TREC) approval.

Analytic method choice

I am using Thematic Analysis (TA). This is a method rather than methodology, according to its creators Braun and Clarke (2006, 2012). As such it allows for flexibility in design and analysis. TA is a qualitative method which accepts the researcher's position and influence on collected data. Braun and Clarke refer to 'big Q', 'medium q' and 'small q' methodological ways of employing TA (2006, 2012). The magnitude of 'q' refers to whether a pre-conceived code or defined coding system is used and/or a theoretical lens or stance is reported from the outset. The flexibility herein allows for deductive or inductive analysis.

Braun and Clarke (2012) state that listing words/phrases under banners, by virtue of sharing common language, renders them descriptive and not themes. I am using an inductive version of thematic analysis.

By its nature, I felt my study required this inductive method. I did not have hypotheses which may have enabled pre-coding for analysing my dataset, for example.

In conducting TA an analyst inevitably forms a relationship with data collected by getting to know it, and organically working through the inductive process, extrapolating meaning eventually arrives at themes. This cannot be a detached encounter. I was not looking for a detached experience. What I read or take in will be perceived through my lens: my gender, theoretical, cultural, political and personal experiences. This is in keeping with Braun and Clarke's (2012) essence of themes being more than descriptions.

Whilst other qualitative methodologies exist, e.g. Interpretative Phenomenological Analysis (IPA) and/or Grounded Theory (GT), they seemed too rigid and inflexible for my purpose.

Using one data set at a time, like IPA, before considering emergent themes and/or uniting themes across the whole data set seemed too linear a process style. GT also uses the idea of emergent themes. The idea of emergent themes appears not to take enough account of

the researcher's bearing on data, implying they hold a passive role. Emergent theme also implies one way of perceiving or understanding something is present. As a psychoanalytic psychotherapist this is not something I conform to: there is often more than one interpretation to make.

Trying to understand meaning individuals place on their experience, as IPA suggests, is of interest to me. However, the more linear style did not seem to fit with a reflexive, immersive, multi-layered-meanings and beginning from a place of not-knowing, of this study.

Braun and Clarke's (2012) TA fits with a psychoanalytic, observational, open-minded, immersive approach allowing for variations in meaning and/or interpretation of language, demeanour and/or actions. Brown in 'Reflexivity in the Research Process' mention 'theoretic insights follow the observation' (2006, p185). Subsequent advantages and limitations of my choice will be discussed later.

Design

I approached data collection, in a similar way to the literature search. I sought broad discipline diversity in participants, as described above, with the expectation of rich and fruitful data.

I developed twelve semi-structured interview questions (Appendix IV). Questions were intended to be open to encourage story-telling, elaboration, interpretation and direction to be led by participants. Subjectively, questions were oriented to aspects of infant/under-fives' mental health but with broad scope for participants to share experiences and opinions.

Interviews were typically 30-40 minutes duration. Each interview was recorded by Dictaphone with tapes of 15-minute capacity. Tapes had to be turned around and/or swapped mid-interview. Though minor, I felt this was inconvenient and/or disruptive to the flow and continuity within conversations to varying degrees.

I had a limited number of recording-tapes available meaning I needed to transcribe interviews, more or less once they had been completed. Transcription, anonymous coding and data storage were completed by me. Thematic analysis did not start until all interviews had been transcribed.

I observed the following TA protocol:

- First phase: Familiarisation of the dataset
- Second phase: Generation of codes
- Third phase: Constructing draft themes
- Fourth phase: Reviewing potential themes
- Fifth phase: Naming/defining themes
- Sixth phase: Report writing

(Braun and Clarke, 2012)

During interviews it was impossible to avoid noticing certain phrases or words, or repetition of similar comments. I realised familiarisation is not something which starts and/or ends concretely. Noticing how and what others reveal along with countertransference are key tools as a psychoanalytic psychotherapist. These are aspects of my work I tried to bring afresh to each interview.

The transcribing process was a large part of the familiarisation. Once transcribed, during my first read through of each transcript, I noted down my initial thoughts and countertransference to the material. Second and subsequent readings identified stand-out phrases, words or sentiments and I started to wonder about meaning or intent. Examples of these can be found in appendices (Appendix V).

Familiarisation and code-generating are not passive functions. I immersed myself in the data becoming intimate with the language and developing a relationship with it. I tried not to consider collections of similar properties as themes in these stages. In keeping with Braun

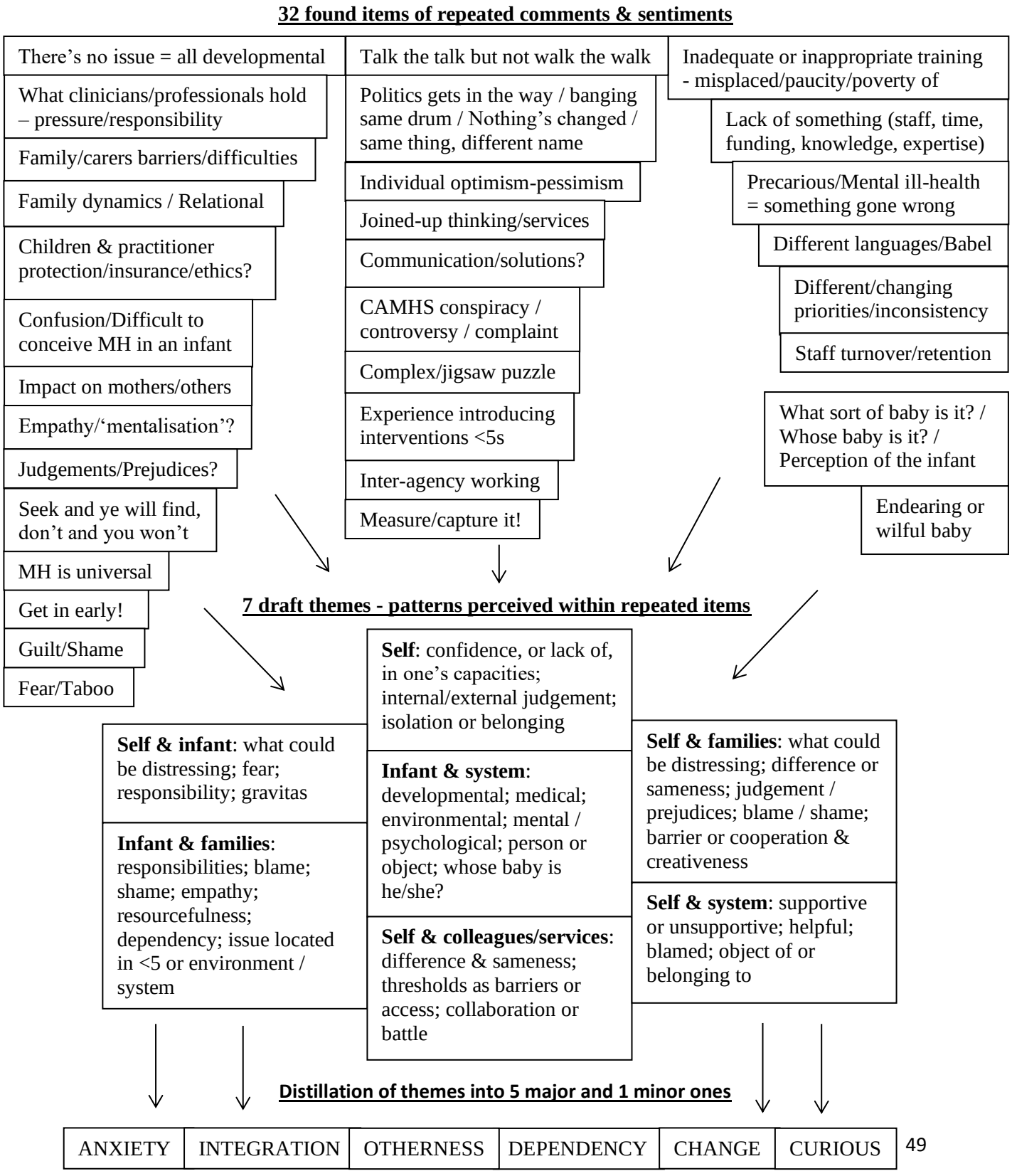
and Clarke's (2012) guidance I codified the whole dataset before settling upon any themes or defining patterns. The process of analysis took shape over each pass with increasing familiarisation of the text.

Sometimes parts of the inductive process were quite concrete. For example, lines of transcripts were all about and I moved them into different piles. See Appendix VI.

During the third phase I actively sought patterns and looked for clusters of similar meanings. I developed some broad draft patterns and themes. TA's flexible non-linear phases were user-friendly. Going back-and-forth through phases three to five I was able to settle on definitive themes.

Chapter 4: Findings

Through TA's inductive process I initially found 32 items of repeated comments or sentiments. From these 7 potential themes were drafted. Continued induction distilled the 7 into 5 main themes and one lessor theme. Here are the findings in diagrammatic form.



The seven draft themes were arrived at from my observations that the 32 like-minded comments were relational. I felt able to distil the 7 further by interpreting the essence or meaning they seemed to encapsulate. I named the final themes Anxiety, Integration, Otherness, Dependency, Change and Curious. Concepts contained within the themes were commonly interwoven. I feel confident that they can be traced back to the original comments and sentiments. The sixth theme Curious was minor inasmuch as it did not gather the amount of attention observed in other themes. However its striking nature warranted mention and felt equally major.

Despite following an inductive process, it is noteworthy two of the main themes appeared in the Literature Review: namely Anxiety and Integration. The literature and analysis have been independent processes. I suggest this finding is testament to centrally important themes rather than discrepancy.

I suggest the interwoven nature of the themes reflects the complexities of relationships and means there is a connectedness between them. I will explain this further. I have set out the themes which now follow in a purposeful sequence.

Anxiety

Participants expressed emotional variety within relationships with under-fives and families. What they presented were mostly challenges and stresses so Anxiety most aptly captured this. Participants described emotional impacts in terms of their own feelings, infants' perceived impact on families and/or familial or environmental influences on infants.

Physical stresses were referred to by some participants, e.g. impact on the mother's body and her hormonal state. Participants viewed these as having being significant, believing sometimes they are overlooked. One participant said:

> *… up to about when the child is 2yo mum's hormones are still not the same as before* [they had the baby], *and if mum is showing a lot of anxiety, then the child is*

The participant conveys how anxiety travels from mother to baby, physically and emotionally. Pregnancy and childbirth is a massive undertaking on the part of the mother, as is the adjustment to parenting for the parental couple. No participants mentioned the toll, hormonal or otherwise, of the birth itself on infants.

Participants expressed relational links between environments and circumstances of families and the wellbeing of under-fives. Complexities were recognised within the emotional capacity of the parent/carer to attend to their infant(s). One stated:

> *the big thing about under-5s mental health needs is that it's so closely, caught up with parental mental health and parental responses, particularly infant mental health needs*

This contingency was commonly reflected:

> *it really lies in, not mental illness at all, but around emotional health and development, and attachment, and relationships, and for a baby to begin to build relationships and begin to have a sense of themselves, a healthy sense of themselves.*

And again:

> *predominantly, I think about attachment and relationships; parents or anybody else, significant other, may have or not have a relationship with* [the infant] *... but, yes, definitely for me, under-5s is relational.*

Early on it was evident the phrase 'mental health' when linked with infants/under-fives, particularly if referring to difficulties, appeared to stir anxiety and controversy. Participants grappled with different ways to think about this concept.

This excerpt portrays a commonly shared anxiety about diagnoses and labels:

> *I think they do experience mental health difficulties but not in diagnostic label terms that we give, but I think more in terms of developmental trauma, distress; so it's not depression, or anxiety but more in terms of the relationship; it's not about being anxious about particular things; but from my perspective… it's more about the relationship and the distress or anxiety, or the availability, or the need being met; that core parent/care-giver relationship.*

For some, anxiety or distress in infants was framed within medical, developmental and/or behavioural models. This excerpt portrays one view of similarly shared opinions:

we, perhaps, don't think about it, so much, in terms of mental health … I think we think a lot about behaviour, er, in the under-5s and, perhaps, less about putting that under a mental health umbrella, but, um … obviously a lot of behaviour is their expression of their mental health needs … I think we don't always use the right phrases, you know, to help us think about things properly.

I remember my countertransference of discomfort as participants challenged me over the controversy the phrase I used raised. This excerpt summed up repeated sentiments which transferred palpable anxiety:

we don't call it mental health difficulties, um, …. If you gave it a different name

I addressed the controversy and anxiety stirred by the phrase during the interviews. I felt addressing the matter avoided possible hindrance of the task had I not done so. This participant exemplified the hot topic and reframed it:

I think we need to be really careful, um, in labelling it a mental health difficulty, because I don't think it is …. It is an attachment, relational, difficulty …… Controversial, but I don't really think that children, of that age, should be being treated in mainstream mental health services

Participants commonly used relational or attachment terminology demonstrating its common place. However they shared having conversations with parents and families about such matters increased anxiety.

Participants believed parents preferred a diagnosis of something medical or neurological, e.g. autism spectrum disorder (ASD). They repeatedly expressed parents' discomfort with, and sometimes rejection of, attachment and relational formulations. From the professional's perspective this participant said:

I think, it can be difficult discussing and sharing, with families, your formulation if it includes that, actually there's something about the family's relationship with the child that, you know, perpetuating, impacting or causing, you know, partly causal in how they're behaving and displaying their emotional needs, um, because that feels like you're blaming the parents; and they do feel incredibly blamed, and find it really hard to accept, understand, even when you try to put it in the most gentle way, it's really … it can be really hard, a lot of families really struggle.

With parents/carers in mind another said:

it's really hard for parents to hear … because they don't want to hear that attachment may have been the problem ... It doesn't matter how much you try to give them examples of it happening in perfectly ordinary circumstances, um; all they're taking away from that is, actually, that you don't think they love their child … boom, that's it, they don't want to engage…. "We've tried everything"; it's nothing we're doing, so they want to locate the problem in the child.

This participant shared their hypothesis regarding parents'/carers' preference for a medical diagnosis:

the medical model ... families feel easier because there's something to blame, you know, there's a problem and, a doctor can diagnose it and fix it.

Illustrations suggested anxieties felt by parents are also felt by professionals, seemingly fearing they might appear judgemental unintentionally. Guilt, blame and shame were powerful emotional anxieties present in the data.

Working with parents inevitably seemed to mean professionals reflected on their own capacities. This participant shared:

you know, as a working mum myself, I know I put my children in child care but what is the outcome because that is the main driver; there is no real choice for families these days …. Everyone's being forced out to work …. That's got to be against some human rights.

This suggested anxieties regarding judgment resonates and can mean professionals judge themselves. 'Human rights' appeared to speak to the gravitas with which painful parental decisions are made.

The next excerpt suggested anxieties are associated with fears of causing harm and the weighty responsibility felt by professionals:

I said I'm really uncomfortable telling the family this, as a single practitioner, as I think it needs to be something the family needs to hear with a multi-disciplinary team around them because of the damage that message gives

Beyond the anxiety of working with parents some conveyed anxiety regarding direct work with under-fives:

one of the concerns… was that my project might cause distress to the children …. some idea that by intervening you were going to cause distress, rather than actually seeing that the children were already in distress.

Some disciplines were categorical about direct work with and/or suitable interventions for under-fives:

we don't work with under-5s

I wonder about the helplessness felt to be transferred/projected, by under-fives and families and/or their countertransference, feeling excruciating for professionals. One participant summed up the experience of the work shared by many:

It's really a grinding challenge.

Participants expressed some frustration associated with their understanding of parental capacity to bring about change required by under-fives. One said

> *gosh, it feels like some treatments are destined to fail before it starts, because the expectations can be so hard on the family, it's unrealistic but then I think some things become so entrenched*

This element of hopelessness and/or despair came through here. These are painful emotions to bear as part of one's everyday work.

Some participants expressed feeling overwhelmed and having a sense of working beyond their expertise. This participant stated:

> *…I do believe we need specialist care; we absolutely do, to make sure that…* [universal services] *don't go too far beyond where we should, without knowing it, and do more damage than good;*

This participant repeated the fear of damage being done and, that a certain pathway could be defined and would offer relief. This hints at containment professionals require.

Many participants seemed moved by their participation in the study. They experienced it as an opportunity to express how their work affects them and their thoughts about it:

I don't get to talk about this, so it's very cathartic

It seemed an important repeated sentiment: A need to talk and share being expressed; and something significant about the role I provided for participants even for the short duration of the interview.

The above demonstrates professionals working with under-fives and families bear a great deal of emotion and responsibility which needs containment for expression and working-through. It is important that containment is clear, available, accessible and reliable. This participant expressed:

> *…it is about having a proper pathway through to infant mental health CAMHS' services, and being really clear what they are and what the criteria would be*

This sentiment indicates pathways for containment, support and/or expertise required to manage overwhelming anxiety-provoking states are not available. Participants commonly expressed the above and a desire for more integrated ways of working together.

Integration

The way in which participants presented ideas and meaning of integration seemed important because of the described bearing on working practices and outcomes for under-fives and families. Beliefs as to what forms of integrated services would most suit needs of under-fives and families were dichotomous: either multi-disciplinary services under one system/organisation/roof, or separate specialised services with clear lines of communication for joint- or inter-agency working and accessible referral pathways. There were also different opinions regarding integration being experienced here and now or whether it was lacking. Perceptions related to aspects of collaboration and/or communication. Communication included different models and language of perceiving under-fives which can negatively impact inter-agency working. Conversely there was consensus regarding what constitutes successful integrated working relations and systems.

Some spokespersons of good inter-agency collaboration said:

> *I think there's some really fantastic pieces of work that goes on … certainly, you know, a lot of thought goes into young children's emotional health … there are lots of ideas and thoughts around*

This statement conveyed both elements of fantasy and reality. It is clear integration is considered necessary and there is recognition that skills and expertise are available:

> *you have the intention of, you know, communication and collaboration, because we all need each other; no one service is going to be able to do it all but we can really share the expertise across all; ….you know, it's bringing them altogether.*

Elements of mystery and wonder expressed, via expertise being 'around' and the task being 'bringing them altogether', suggests participants' typical experience is not availability or accessibility.

Participants were united in beliefs that work/threshold complexity had increased and empathised regarding the mammoth task all face. Here the anxiety of feeling overwhelmed met the magnitude of the task of trying to meet under-fives' mental health needs:

> *I think, once things start getting a lot more tricky, you know, once that multi-agency team have exhausted their level of skill, it's getting that next level of psychological and emotional support; it's nigh on impossible, it's so hard*

The lack of something joined-up was frequently expressed. This participant described a disjointed/disconnected puzzle:

> *there are a lot of solutions, you know, where everyone might be working in isolation; whereas if we could come together and share that information, and pool that knowledge; … people have got different parts of the jigsaw puzzle, and it's only when you bring it together that you can form the whole picture.*

Hope is expressed above in the belief that solutions exist yet the mystery again of how to bring together disparate parts of a whole. Some participants perceived the difficulties lay in different models and ways of thinking about under-fives:

> *I think, moving away from a purely behavioural view of children and to a wider deeper understanding of thinking about why the behaviours are there really … you know, there's been a lot of behaviourist-style work that's been very populist … but it's not the only thing.*

The value in integrating other, different and/or multiple ways of thinking about the mental health and wellbeing of under-fives was repeatedly mooted. Forming, holding and maintaining an integrated picture of individual under-fives and families seemed part of participants' concern.

There was consensus regarding the perils of un-integrated working. However there were mixed opinions regarding what professionals might do in certain scenarios of un-integration, e.g. lack of connectivity with other agencies and/or inaccessible expertise which could leave under-fives' and families' mental health needs being unmet.

Dilemmas included: perceptions that expertise was beyond particular personnel or service; families not meeting referral criteria to known other services; specialised services deemed non-existent or inaccessible; and/or inter-agency dialogue not felt possible. The frequency with which these difficulties were raised suggested this was professionals' consistent experience.

Participants shared how they manage such dilemmas with awareness of the direct impact on their working relations with families. Some professionals shared that they might take families through a formulation and a process of elimination to help parents/carers draw their own conclusions that nothing is available to help them rather than spelling it out themselves; some might lead parents/carers to realise they would have to access another service themselves without the present service being able to link up with said other service to facilitate smooth passage; some might avoid having certain conversations altogether thereby avoiding alerting families to options or rather the lack of, e.g. interventions or specialists. These scenarios were particularly apposite when mental health factors were deemed to be at the root of under-fives' difficulties. These were disturbing findings both for professionals and for under-fives/families. This participant described one excruciating experience:

> [you] *would recognise that the primary problem would be the child's place in the family, in their environment, their sense of security and wellbeing but, you would not*

raise that with the family because there's nowhere to send them and it risks doing more harm than good; you know, tell a family and then have them carry that round with the child they're trying to look after; so we don't; what we do is, we know it's not this or that, we've done everything we can, other services might be able to help but we don't really know what they uptake of that is

Here anxiety meets lack of integration. The painful burden and fear was repeated: that they as professionals might cause 'more harm than good' if they pass some knowledge onto parents. Participants repeatedly conveyed a sense of having no service, nothing helpful, to pass families onto when they had exhausted their own expertise. The emotional turmoil felt by professionals is avoided, (temporarily) for themselves and families, by not having conversations. Yet professionals know they bear this internally.

Other ways for professionals to defend against psychic pain associated with their work was to reframe their frustration regarding un-integrated services. There was anxiety that this was experienced by families nevertheless:

there's a few people who are offering things but, it's quite disjointed, so it doesn't feel like there's a clear progression, which is really difficult, um, because it doesn't make it a smooth service for the family

Some participants reflected:

I'm not sure they always ask about attachment or about the relationship between mum and baby; but if people do see more issues and difficulties, where do they take them because there isn't a service.

This seemed to reflect how isolated and/or compromised professionals can feel feeling un-connected and/or that services are non-existent. This participant reflected:

if you're a practitioner and you don't think there are services, then you won't particularly look or identify, or whatever, and do people really know

The doubt and defeat in this comment suggested that something fundamental has to be immobilised from seeking what might be available. The pointlessness and futility repeated:

and a lot of times, now, the kick-back that I get from my colleagues in the XXXXXXXXXX services is, well, the reason we don't think about [infant mental health] *it's because there isn't anywhere to refer anyone onto, so what's the point in identifying it …and that is really worrying, isn't it*

It was as though this professional had a sense of kicking themselves too, perhaps wishing that they had not even pursued another service. Perhaps they were in touch with some humiliation and vulnerability being exposed and in need. The level of frustration and anger expressed regarding inter-agency working became almost apoplectic at times. The level of passion seemed also associated with participants' awareness of the implications for under-fives and families.

The next excerpt conveyed the potential for creativity within inter-agency work, yet also pointing out hazards:

> *we have tried in the past* [two teams to work with same family] *but then we've had splitting of professionals and the family getting mixed messages, and it's really not helpful, without an effective multi-disciplinary team*

This suggests attempts to join-up and be more integrated are not straightforward. Splitting, confusion and/or loss and further fragmentation can result. Though integration seemed desired it seemed difficult to achieve.

> *I think we can be quite split off, as professionals ... because, you know, social care does one thing, CAMHS does another thing, education another ... and, actually, we need to start thinking, well, earlier on about how we link up and create a more joined-up service, which I just don't think there is, especially not the little ones, I just don't think it's there at the moment*

The desire for joining-up 'earlier' in a service-journey matched the prevailing idea that under-fives and families required early intervention. It seemed something very important was being conveyed about the early stages of relationships.

The prevailing desire for integration appeared to be associated with the prevention or avoidance of isolation and/or fragmentation. This participant identified:

> *it's that thing about specialisms ... things have become quite specialist and become quite fragmented ... and, actually, I think, what needs to happen is we need to bring back to bringing everyone together.*

This sentiment seemed related to, but also a little different from, the idea of a jigsaw puzzle mentioned. Repetition of 'specialisms'/'specialist' linked with fragmentation and

bringing back ‘everyone together’ seemed associated with difference and/or sameness: special-ness seemed worrisome; ‘everyone’ needs to benefit and share in the goods/services/expertise of what might be wholly available; and ‘fragmented’ brought a sharpness into focus. Proximity and degrees of integration are difficult to address, it seems, and does involve negotiating with Otherness.

Otherness

Splitting, as referenced above, is understood as tension between separate different parts of a whole. Perceptions of otherness were brought by participants and seemed associated with difference and diversity and tensions between difference-sameness.

Participants voiced the otherness of under-fives:

> *…little children are expected not to behave, little children are expected not to sleep very well, you know, that’s normal, little children are expected to have tantrums, you know, that’s normal, little children are expected to be picky with their eating, that’s normal… they’re seen as variations on the normal but not warranting, um, input or a service, um… to an extent that’s true, yes, small children’s is not as good as big children’s sleep…*

Though the emphasis above is on ‘normal’, the general concern that under-fives require thinking about in terms of behaviours was nuanced. The same participant went on:

> *but there’s poor sleep in a toddler and there’s really bad sleep in a toddler, um … so, I think, it feels like their needs are minimised because they’re small and they need a lot of care anyway, um, yes … to me, that feels like the biggest reason, is that the mental health needs of under-5s are minimised, um, as being part and parcel of normal toddlerhood; you know, toddlers are tricky anyway, so you know, that’s just what it is*

This demonstrates the power imbalance which exists around very young children. It highlights professional awareness of under-fives’ vulnerability, neediness and dependency which is likely to be another source of anxiety in the work.

Under-fives’ otherness was also demonstrated via different ways to think about them, e.g. medically, neurologically, developmentally, psychologically and behaviourally.

Perceptions could generally be seen as determinants of services/interventions. Differences between self-and-other disciplines were noted thus:

> *other professionals' thinking about what under-5's experience, you know … do they conceive under-5s can have mental health problems; what pathway would somebody get to, to get through to a mental health service for under5s; so they'd have to go through the primary health service, say GP or HV, and think if certain presentations are presented to them, what their understanding of those presentations are; that can completely affect the direction that goes off in.*

This suggested ways of thinking about under-fives appeared to be somewhat concrete affecting who refers to whom, and what services/interventions might become available to them. Behaviour could divide participants: some viewing it as part of development and others as communication of internal states.

> *I don't know whether it's because of your professional background and where you've worked, I think that shapes you; and I'm not sure other agencies, if they haven't had the same type of training and experience, would even think about an infant having emotional health needs or developmental needs, or you know under-fives, and linking behavioural distress could be seen as communication of that.*

There were conflicting opinions regarding specific disciplines. A particularly interesting finding related to misunderstandings and split opinions regarding whether child and adolescent psychotherapists work with infant mental health and under-fives. One participant said:

> *…it's very poorly understood; …different professions do have some understanding but, on the whole, it's limited… I think, again* [infant mental health is] *very behaviourally understood*

The above remained true whether participants worked within or were external to CAMHS. As a child and adolescent psychotherapist working in CAMHS this was uncomfortable listening. Such borders and issues of difference were theorised about:

> *I think that's the problem, that we don't all speak the same language; we all have different priorities and thresholds….*

Another theory shared multiple times introduced the idea of a 'risk-filter' particularly in relation to CAMHS' border:

> *I think it's that* [the risk-filter] *makes it difficult for an infant mental health difficulty to get through; you know …5 referrals of adolescents, who are self-harming and things, it's difficult to allocate something that, perhaps… a health visitor could deal with that*

This idea brought together the insignificance of infants, as another way to think about their small-otherness, as well as an understanding of impossible decisions professionals seem to have to make, e.g. adolescent versus infant. There are links with Anxiety regarding what cannot be thought about and Integration regarding an unspoken reliance on others, e.g. health visitor. This presents a hopeful, or wished-for, idea of other-safe-hands when demands mean oneself/one's service cannot hold under-fives. This poses difficulties if other services are equally stretched with competing, demanding tasks and priorities to attend to: What then?

There seemed difficulties whether there was capacity to attend to infants or not. This participant shared:

> *thinking about what drives the behaviour and the distress, that the child might be experiencing, I think, is very difficult to tolerate; because if people begin to feel that under-5s have an experience of the world of adults, of their parents, which is in touch and which is complicated, and is under-attended to by the services, in a way, then it poses, you know, perhaps, services can't afford to notice it*

Strong assumptions were portrayed between under-fives and particular practitioners/disciplines, e.g. health visitors and paediatricians. This seemed to reflect the dominance of a medical or developmental model. One participant stated:

> *we send to paediatricians, and there's HVs; what I have done is give advice; we do more these kind of things…I think, generally, we don't work with under-5s*

Another was more vague about who can serve infant mental health:

> [under-fives] *it's something we don't see in this service very much; so who does see it; who is it obvious to; we don't tend to get the referrals or, if we have duty calls for under-5s, they tend to be pushed to health visiting; although I don't know how confident they feel, …. I wonder if anybody is actually thinking about it, infant mental health; that's my thoughts really*

The lack of clarity around work with under-fives' mental health was repeated. Either self or other could be regarded as having or lacking the necessary confidence, skills or

expertise. A frequent perception was that expertise required by one professional was assumed to be elsewhere with an-other professional/service. In this case, frequently the other was deemed to be withholding or blocking access to something helpful that they possessed.

This was particularly striking in relation to CAMHS, as a striking number of participants expressed exasperation over their thresholds and processes. As a CAMHS' clinician it was difficult to hear the animosity expressed. This excerpt captures some more of the feeling:

> *there is some fantastic multi-agency working but it does NOT include CAMHS for under-5s because they say they don't see the children! So, I never refer!*

Participants spoke vehemently. There seemed to be a need to vent frustration and/or seemingly anger through, or directly to, me. Interviews seemingly provided an opportunistic conduit.

The vehemence of frustration expressed seemed to evidence its long-standing nature. Participants expressed mystery regarding CAMHS' border and accessing services for under-fives. On CAMHS' 0-18 year old remit this participant said:

> *My colleague…would say CAMHS don't accept referrals for under-5s; XXXX tried multiple times; I've worked really hard to try to understand CAMHS' processes and how they consider cases.*

The mystery appeared to instill an idea of conspiracy with it: that self was being kept out no matter the effort to get in. 'They' suggested collusion by those within keeping those without out. Nevertheless the statement conveyed the participant's belief that they were knocking on the right/appropriate door and, what they needed was on the inside, based on the multiple attempts made.

Strong degrees of mystery between professional-self and professional-other were expressed multiple times. This participant suggested:

> *it's about getting everyone to understand who else is out there, what they do, how they do it, how you might work together, um, and that.*

Links with Integration are apparent here, yet there is something distinctive in the repeated mystery within 'who', 'what' and 'how'. Otherness seemed to have some alien quality. For example, the bafflement of thresholds and borders, and other languages, referred to. It is noteworthy that pathways are current parlance and yet participants mainly perceived thresholds as blocking devices not accessible gateways. This excerpt is representative:

> *I think we have barriers, don't we, in terms of where agencies stop/finish, you know …I know we need boundaries, I guess, but sometimes they can be like barriers… and I think, that can get in the way of thinking more dynamically… about how each agency can work together more, how to cross those boundaries, in a way that might be more helpful… they have their own priorities, they're up to here* [gestures to head area] *and it's very difficult.*

This expressed the mix of hope for integration and rivalrous tensions. The tension seemed related to haves and have-nots of knowledge, capacity and/or resources. This participant stated:

> *what you have is that one team has to prove to another team that the child meets threshold to access their service, and so that team is upping the ante but you can't up the ante around infant mental health and trauma in childhood without doing damage to the parent; it's a very fine line*

This statement highlighted the felt angst and internal dilemma including an awareness of jeopardy for children/families. The focus in the statement is on the damage to the parent. Consciously or unconsciously there is a sense of being caught up with power dynamics again.

Sometimes access to an-others' expertise or skills was linked to pragmatism and/or finite resources. This resulted in collusion of a more empathic kind: a recognition of shared-experience as the following two excerpts demonstrated:

> *I presume it's volume, you know, capacity…*
>
> *same as every agency, everybody is really, really stretched*

Some shared assumptions highlighted complexities between self-and-other: on the one hand something joined-up in likeness/sameness and on the other demarcations between self-and-other. This participant said:

we always think somebody else is doing something, or it's somebody else's role to do something

The tension Otherness has conveyed seemed between the pull towards joining-up, e.g. we are in this together and we don't want to feel isolated, and how this may be achieved when we are so different, e.g. the alien qualities and/or conspiratorial sensibilities. There are links with Anxiety and Integration. The dynamics of us-and-them, depressive and paranoid-schizoid, tensions have connections with the next theme.

Dependency

Otherness touched on perceptions of haves and have-nots, Dependency focuses more on the deficits and a sense of neediness held in the self-professional/self-team. This theme exemplifies concrete concepts which, if only deficits were made replete, then difficulties would be resolved. Missing or absent objects included resources, funding, personnel and/or knowledge in the form of understanding, expertise, training or education.

It has been impossible not to present deficiencies as a list, in a very concrete way, due to the volume, vehemence and way grievances came across.

Participants commented thus:

I don't think I do get enough time.

[under-fives mental health] *is harder to identify, because people don't have the knowledge about it, or they don't have any services.*

there's not enough space to think properly about the child's experience; might not have properly thought about that child since last week, and there's not enough space to hold the child in mind.

I think it's about training… on child development; …not just walking, talking, sitting up, but brain development… it's not just about attachment but, you know, stages of development, those different theories which might help someone conceptualise when it goes awry, what are the possible reasons and understand more from the child's perspective.

I suppose one of the barriers is that's there's just a lack of resources; we don't have enough staff or provisions locally… in the area

Participants believed parents/families were in deficit:

not just in terms of funding but in location; where things are set and how accessible they are to parents who have under-fives; they might not be in school, or how will they access those [services]

I worry about families that don't have access to the service because I worry that the stock response to risk is separation [removal of children]

how much support and training are young people, new parents, getting about being a parent, transitioning into being a parent, and the ethics about not having a service at that point

There were ideas that under-fives were in deficit in a number of ways.

their needs are minimised because they're small

Infants are completely dependent. They have no agency and cannot be seen unless

adults bring them to services.

obviously the child can't necessarily bring the view of themselves; how do we think about that; when parents are not in a place where they can take up an offer of a service

In terms of risk of mis-diagnosis/-treatment because of lack of clear understanding regarding what to do with under-fives' mental health:

I think it's [mental health of under-fives] *not talked about very much as a concept, because there is no clear link into a service operant; …we tend to be quite pragmatic, in general, and talking about something as a concept or construct, or a model for understanding, doesn't then lead to improved service for the family, it's unlikely there'll be time spent talking about it, so we don't talk about it; we talk more about risk factors; we talk about parents' mental health; increasingly, now, we're talking about attachment, which is very recent*

In terms of their non-verbal communications being understood:

I think the difficulty for [under-fives]*, is they can only display that through behaviour, and that many services, mental health professionals aren't actually trained enough to understand what might be driving the behaviour; you know, because they're trained in verbal communication as opposed to something else.*

These next comments encapsulated the connection to neediness belying grievances, i.e. there not being enough of something. This participant shared the sense of limitations:

professionals …they can do so much but they will always get to a point when they're not comfortable, or confident, regardless of the resource, training they've had, etc; when they get passed that point then they would want a mental health service to support them and step in; that's not been readily available

Participants repeatedly pointed out limitations.

Dependency and one's own need were brought into focus because others were perceived as being able to fulfil the deficit and/or responsible for it. Frequently dynamics with authority featured. The next excerpt summed up thus:

there are invariably issues within the parent …there might well be parents who don't trust professionals, so you have to build up the relationship; you may well be on the edge of safeguarding issues, and need to take that into account

This participant pointed out: parental responsibility; parent-to-professional dependency; lack of trust within parental/professional authority; precariousness and jeopardy; and responsibility and accountability. As with Otherness, Dependency included power-dynamics both explicit and implicit.

Participants reflected a sense of hard work and responsibility as well as the need for benevolent, supportive management/commissioning bodies who would share the load and burden. There were indications that the latter was not participants' general experience with the following citation frequently made:

high turnover of staff

The safe, reliable, dependable hands longed for (in Otherness also) did not seem present.

The listed format of this theme has given it a droning quality. This highlights different ways to consider professionals'/services' needs: at different times they made be unheard, impossible wish-lists or forgettable and regrettable grievances, or heard as needs to be attended to. The weary tone conveyed by participants suggests the former. Participants often paired solutions with needs which indicated commitment to not giving up, creativity and/or

ideas for change. The idea of adaptability and change presented significantly enough to warrant a theme of its own.

Change

Participants referred to optimum conditions when infants and/or families might be receptive to change. They presented creative possibilities for working better or differently as teams and/or with families. They shared thoughts on adaptation required to implement change. Optimism and pessimism were expressed.

Participants were unanimous regarding the need to work early-on with under-fives.

> *a brand new infant, starting out, they are open to developing in so many different ways*

Participants felt if early intervention was not achieved it resulted in difficulties becoming established and more problems in latency and/or adolescence. This participant captured the common opinion:

> *if we intervene at that younger stage we might reduce lots of different difficulties later on, um, and I think a lot of that is what this younger age group is about.*

Participants linked not addressing difficulties early enough with false economy and resources being used ineffectively.

Participants believed these were obvious links not least because of the physicality of the child too:

> *they are small and you can manage; when they are big, you ask, "well when did this start" and the parents says "oh when they were little"; you say "why didn't you come before"* [shrugs]

There was consensus that socio-economic distinctions could be irrelevant and that issues were more about parenting and parental relationships. This participant said:

> *people need tooling-up and babies don't come with a manual …I think infant mental health goes across the whole socio-economic spectrum and, you know, we have middle class families not understanding the importance of relating to your new-born baby …and all the things that make baby connections happen in the baby's brain.*

Participants claimed mothers are primed and open to retaining information during pregnancy and that pre-birth programmes are beneficial. They demonstrated compassion and sensitivity regarding parents' birthing experiences:

> *sometimes ante-natal classes have been around the act of birthing with key messages, but not actually when you take that baby home: what does that feel like; how are you going to do that; and what can you do to support your baby in the best way.*

Paradoxical to the norm that early work is essential there was a significant idea that under-fives cannot be worked with. This participant shared:

> *when I've talked about working with younger children, or just thinking about the young child, the response is, "what would you do with them", "how on earth could you do any kind of intervention with therapeutic work with that age-group", um …I think people feel puzzled about how you could, actually, work with them;…so if it's playing, "what you're just going in a room and playing with a child"; it's not thinking about that …we think a lot more about communication on different levels… with an adolescent you might be able to sit there and talk to them about what's going on for them, but you can't do that with an under-5, so you have to be a bit more creative, but I think that is a barrier that people don't, actually, think they have the tools to do it; they feel that you'd need, some sort of, real specialist.*

This participant pointed out some of the challenges:

> *I do think* [adults] *find it hard to think and get inside the mind of a child …to think about babies as people… that have minds… and, you know, they're relating… especially when they're pre-verbal …I think people feel out of their comfort zone, that they have to communicate without words… or in a different way, you know, using play or whatever. I don't think people are very confident, understandably, they don't have that training and background.*

Changing the focus and/or opening up dialogues of understanding of what under-fives present with did not seem straight-forward. This participant conveyed the confusion and mystery:

> *I think, it's kind of a bit chicken-and-egg, as well, isn't it; so, if you're a practitioner and you don't think there are services, then you won't particularly look or identify, or whatever, and do people really know… I don't know if that's the chicken or the egg, but the other way round of that is, do people understand mental health in, or poorer, mental health in younger children; do they, or is it a development thing, or is it a behaviour thing; so, I don't know, if it's harder to identify, because people don't have the knowledge about it, or they don't of any services.*

Another put it more simply:

You don't know what you don't know... I think in everyone's general practice they should be alert to under-fives …let's put the lens on the under-fives.

Participants expressed multi-layered difficulties and influences. For some participants external influences came to mind. There was a strong feeling that political winds came and went, changing budgets and focus; some to the good and some disrupting that, which professionals felt to be working and worthwhile. Professionals expressed helplessness in such matters. This participant expressed common frustrations regarding such disruptions:

when the Conservatives get in they want the old red posters to come down and blue ones to go up, um, to be honest, much of it was pretty much the same, but it had to be rebadged, relaunched, you know, it's crazy… certainly the journey started with Blair's government and it was the "Every Child Matters" agenda …and we've come a long way … it works if people have got time and they've heard the message, and that's still not true of everyone.

Participants expressed loss regarding what they had felt to be beneficial, e.g. the common assessment framework (CAF) and Sure Start programmes.

Regarding perceptions of policy-makers and/or professionals in practice this participant said:

it happens that under-fives struggle with mental health and if people don't accept that premise, they're not going to put any weight and resources behind it.

It seemed the place to start was to believe under-fives were worth investing in.

Sometimes developments and changes were felt to have been positive as this participant reflected:

in the early stages of the service, …our focus was very much on the mother; I think what's happened latterly, so in the last, sort of, 5 years, …you see it improving around attachment work, um, the understanding around the needs of the infant, now, is… we, actually, now really do understand that; and I think that what's happened… and, I think, part of it was turning the emphasis… to being on the parent-infant relationship, the mother-infant relationship, …now we're looking beyond that to the father, the partner, as well; …we start with thinking about, so what does this relationship look like.

What was clear from these comments is that policy, theory and perceptions are changeable and can be unpredictable, and changing winds bring unwelcome uncertainty.

There was consensus regarding the current climate was focusing on infant mental health. Some participants who had experienced changes worried about future change impacting their practice. One participant said

> *it's a concern I have – what will happen when the light moves off… um, and how do we ensure we don't lose the progress we've made; once the light goes onto something else, it's really easy for people to start to take away and remove …how to make sure parent-infant services are developed, established and are not eroded again, like they were in the past.*

This captured a sense of helplessness and inevitability.

There were conflicting opinions regarding changes perceived in need over time. Commenting on volume and complexity this participant said:

> *I would say there have been more referrals for under-5s; I think the referrals we have received seem, on paper, more complex, and they've led to more discussions with various services; particularly seen that over the last year-eighteen months.*

Another felt it was the lens rather than the need which changed:

> *2004, we did see a lot of under-fives …there was a strong focus actually on working with under-fives but it kind of …got hived off into parenting …that was my sense of it anyway …which was great that was happening but it meant the work with the children wasn't happening.*

The above suggested comprehending what goes on is complex. Statistics may not be relied upon because different ways of capturing information is not straightforward and what might be being measured changes.

Measurability and evidence-based thinking featured highly amongst participants when considering interventions for under-fives. Regarding introducing interventions this participant reflected the views of many:

> *you need a good evidence base because you're not going to get anywhere without some research evidence that it is effective, um; …you've got to think, can you get a workforce to be able to deliver it; how accessible is the training in that psychological therapy; and then how sustainable; how costly is it ….but if you haven't got that research base, you're not going to be able to get anywhere really, you're not going to attract funding.*

Others pointed out difficulties and risks involved in change and/or evidenced-based interventions. This participant pointed out the need for review and trials:

> *you have to review the evidence-base and find out what is effective, um, and then find out where there is an under-fives service, and see what the pitfalls are, what the positives are, I think, so you learn from others, basically, and then you try and grow the idea of a pilot, maybe, with some good outcome measures attached, to see how it works, and see how effective it is; …the benefit of a pilot is …this has saved so much money because it's a longitudinal study that's needed, or a long piece of research… you begin from professional networks with colleagues, from different agencies, and that can only be to the benefit of families.*

This participant captured the dynamic and multi-faceted aspects of change based on evidence. The level of detail conveyed by some exemplified the complexity of such endeavours.

Evident was that change takes time. This participant stated:

> *It takes a lot of time to introduce anything new, really; often you're changing the mind-set or the culture of the teams; so if it's something new it's helping teams or professionals to understand; and it's about the impact of the intervention or treatment, whether it's worth continuing, but there's quite a lot of work that needs to be done before introducing something new; it just takes time.*

Hurdles and/or potential resistance to change within mind-sets and/or team culture was repeatedly commented on. Similarly participants pointed out teams and services were so stretched that it can be difficult to take on new ideas no matter how helpful to professionals, or beneficial to under-fives and families, they might be.

A mix of despair, pessimism and optimism was expressed regarding the direction of infant mental health and what is believed to be known currently.

> *we do know the "right"* [air quotations] *thing to be doing but, for reasons I can only think are about resources, um, that are about the prevalence of certain models … um, it doesn't get incorporated into the services that are there; and I think there is a real issue around having good evidence, good training, supporting staff, that look after children, giving parents enough information, um, we just don't do it; … it really worries and disappoints me, I suppose, that we've got the information there but we're choosing to not listen.*

Such passion was not my singular experience as participants talked about the professional or political climate, resource-stretched services and/or future-forward ideas.

This participant said:

> *it's not difficult to talk about or raise issues but it's that you've got to do something about it… I do worry about it, a bit, for the future – austerity isn't going away any time soon, is it*

Optimism tried to prevail as this participant expressed:

> *I think one has to remain hopeful …I think there is a move towards that – there's been more funding into perinatal which is some recognition, I think, of how important a mother's state, or carer's states of mind, is for the baby; I mean that's another good start, and that's been driven centrally, um, there's been the first 1001 days project which, again, has highlighted what's needed in terms of under-fives; so the tide might have turned*

Optimism did prevail for the most part. The ebb-and-flow discussed suggested the inevitability of change and the certainty of uncertainty. The repeated experiences described proved anxiety-provoking. Resonating again with the Anxiety theme it reiterates the interwoven nature of all of these themes.

Curious

The following observations are deemed curious because of distinctive and interesting hallmarks. Some data identified different types of babies/under-fives. My countertransference was profoundly stirred, and the points participants made are captured here.

The hidden or missing baby

Some participants identified lost or hidden infants different to something identified as missing in Dependency. This participant described it thus:

> *you know, if there's a child just sitting in the corner, completely on their own, completely quiet, doesn't say hello to anyone… you know, is that a state of poor mental health, or is that because the parent at home just doesn't talk to them, and they haven't learned to speak; or the personality of the child; so, working out what's what, I don't know as we've particularly got the skills, or a workforce that is skilled up in that area to identify … I mean across the board, across the entire board, so you've got for under-5s, I guess the most people that see them is the children's centres, um, the nurseries; health visitors won't see that much of children, they'll see new-borns; I think they see them 6 times in two years, or something, so it's really only a small*

snap-shot that they've got; and it's really very early in the child's life that they see them, isn't it; whereas your nursery will have from 2-5, or until they start school, and they might see them 2, 3, 4, 5 days a week; but those in there, many of them are quite young and not particularly trained, …so it's um; and then there are, on top of that, many children, just at home, because the parent doesn't work, they haven't got the money to take them anywhere, or they're agoraphobic or never leave the house, don't take up the free childcare offers; then if you follow that through, and they get to school-age, if they elect to do home-education no one knows, no one knows, unless they go to a doctor, or dentist or something. Hidden or in plain sight and no one's got the time or the skill-set to see.

Sentence after sentence this participant listed the many ways that they believed children are unseen or lost by professionals/services, building to the crescendo 'hidden in plain sight'. The summary ends bleakly where no one was felt to be available. It had a sense of children being (un)seen and unheard and perhaps a broader social, political and historical resonance regarding an infant's place in society. The next participant seemed to concur:

I think the majority; even in schools and our education system there's no preparation for becoming a parent; society is just caught up in achievement and busy-ness.

This demonstrated an awareness that priorities change in society, and the value of parenting, and with it therefore the infant, appears to fluctuate.

This anxiety is echoed by another:

it's really worrying how children's services and women's services are … I don't think they're given the attention they should have

This idea is possibly linked with the conflict over whether under-fives have mental health difficulties, and/or other previous points regarding winds/focus changing also. Rather it seemed more important and a point about slippage, missing and absence from minds. This participant poignantly said:

there's almost the idea there aren't any difficulties, there aren't any under-fives

If one does not see under-fives, under-fives' emotional needs and/or under-fives' referrals then they do not exist.

These observations referred to something about not about attending or attuning to infants' needs and attachments. Rather babies/under-fives seemed almost concretely missing: Not in people's minds at all.

Revered or feared baby

In contrast to the absent baby, a few participants seemed to imbue infants with certain qualities which did not quite belong in Otherness. One participant said:

> *very young children are endearing and you know, everyone wants to, naturally, nurture and protect, um …empathy can be hard if you're thinking he's being horrible, difficult or naughty, nasty*

This participant was careful to make a distinction between under-fives themselves as separate to their behaviour. Participants were generally very careful not to locate persecutory or so-called negative qualities in and/or demonise children. However qualities of a more positive nature were more easily located. The above participant spoke with global confidence that 'children are endearing' and 'everyone naturally'. There was a split between an idealised baby-version given reverential status, and the more conflicting reality that some under-fives are difficult to like. The un-palatability of 'empathy' might be associated with the unpalatable feelings towards a child, e.g. the knowledge that some adults do have the capacity to be 'horrible' or 'nasty' to under-fives.

There are likely links with guilt, self-criticism and judgement regarding possible thoughts and feelings harboured by parents/adults; or the ordinary love-and-hate within relationships which is difficult to consider; and/or the wider judgement of societal conventions and laws.

This participant talked of adverse experiences witnessed and/or experienced by infants being difficult for adults to bear. They quoted parents' comments:

> *"gosh they can remember that?", or "they wouldn't have noticed that was going on because they were only 3 or 4" …"they don't feel pain or they didn't see"*

The idea that under-fives could remember what experiences adults have brought to bear on them provoked anxiety: fear of retaliation, blame or shame, challenges to adult imperfections and limitations. Some extremely adverse situations were discussed. However so too were more ordinary challenges for families which could provoke the same anxieties, e.g. financial difficulties, ethnic/cultural challenges, parental disability/mental health and/or employment/unemployment issues.

In contrast to a revered or feared baby, these participants brought to attention a real baby, yet this seemed difficult to hold in mind.

Whose baby?

An idea was raised regarding the need to take responsibility for under-fives in difficulty in a way which has not been described already. This participant stated:

Mental health difficulties are maladapted behaviours

I understand the statement and it is not intrinsically incorrect. However it opened up provocative ways to think about its nuances. 'Maladapted' seemed to suggest something more broadly unacceptable about under-fives who misbehave and have difficulty finding their way/place in society. In this case there seemed a shift towards reclaiming the focus from babies to adults. Under-fives need to fit into society rather than the other way round. The power of the statement warranted some exposure despite it also being a reality that under-fives do need to adapt and sometimes require help with adaptation.

The statement does not seem to be about blame or demonisation. Neither does it seem to claim or recognise the baby as a person/individual. It seems imbued with something detached and dehumanising. It focuses on the maladaptive behaviours requiring adaptation where someone unidentified is hinted at and seems responsible. Whose baby is this? There

seems little, or no, room to contemplate or attune to the under-fives' experience. Who will claim this baby?

Claiming the baby

Attunement and attachment were discussed frequently by participants in regards to parents'/carers' tasks and/or the importance in parent/carer-infant relationships. Only a few participants spelled out their opinion from the perspective of the baby.

> *a baby's or child's behaviour is a barometer of their environment … they will use their crying and behaviour to alert … you know, you can go through, on your fingers, are they hungry, are they … but what aren't they getting; a baby is always trying to tell us something, and it's being alert and attuning to that baby's needs … there are all sorts of types of parenting, aren't there, leave your baby to cry, you know, all those conflicting ideas of what you should do with an unsettled baby … maybe they're a baby that needs lots of cuddles … there's lots of research that, you know, babies do need different things; if you've got a cuddly baby, there's lot of unhelpful advice out there, as well, and as a service we try to look at what that advice might mean, and what would be best for your baby; that's where the baby massage tool really comes in, because they can see when baby's had too much, they can look at their face, you know, and see.*

This participant captured an experience of looking and really connecting with the baby who will signal what they need. This seemed the essence of taking in a real baby and holding them in mind. Another participant said

> *something about attunement and being able to notice and pick up on that; Attachment has become a catch all, talking about, but what does it really mean … we used to think about attunement slightly like tuning into a radio station, and sometimes you get it right, and other times you have to take a little bit more time. … I was just thinking about babies crying and, you know, the response to babies' crying and how to view that.*

These excerpts brought to my mind a real attention to detail to micro-communications. These findings seemed at odds with the previous babies: unseen/unobserved and/or not alive as an individual.

These curiosities are all in keeping with different ways to think about under-fives and the capacity to which they can be held in mind.

Chapter 5: Discussions and Conclusions

My exploration into what needs to be understood by child psychotherapists in their role working with under-fives in mental health has brought together existing research and findings from my study. What follows are discussions on: 'Tales of the expected' presenting congruent data and material understood by child psychotherapists; 'Tales of the unexpected' containing data which brought something new to light for me and which could be beneficial for psychotherapists and others to understand; and 'Curious tales', a minor theme with a major impact which may also enlighten and have bearing on the work of infant mental health. Conclusions with clinical implications and future application follow discussions.

Discussions

Tales of the expected

Through the literature review and study findings I expected to learn of the challenges and stresses associated with working in the area of under-fives' mental health/wellbeing. The field of mental health is generally recognised as emotive. When combined with the vulnerability of very young children it seemed likely emotions may be amplified and/or more complex.

I wonder about deep-rooted primitive instincts/drives and ordinary internalisations regarding direct under-fives work. As large able independent adults we are mindful of potential damage to and the care required by the small vulnerable dependent infants of our species, e.g. the need for protection. As a psychoanalytic psychotherapist I am minded to reflect on resonance with our own early experiences, long-gone and often consciously forgotten. From these points comes the potential for individuals or systems/networks to re-enact something of the lived experiences/past (either infant's/family's or our own) in the here and now with our clients. These things seemed alive in my participants.

I will discuss expected findings using familiar headings: Anxiety, Integration and Change.

Anxiety

There was congruence between reviewed literature and my findings regarding the emotional load professionals manage in the course of their work.

Psychotherapists, in contrast to many disciplines, use the emotional content and experience in encounters with under-fives and families to inform their work. Countertransference and its use were encapsulated by Dr Jones' (2013) single case study. Whilst other disciplines do not specifically work with transference and countertransference it was evident many professionals valued opportunities to think about them (Zeanah et al, 2006; O'Neill et al, 2016; Williams et al, 2019). My participants expressed value in being able to talk and think about their work with me.

Some anxiety was linked to conflict and/or distress that differences of opinion might cause. My findings replicated past research in that participants identified certain conversations which were difficult to have (Alakortes et al, 2017). My participants expressed a sense of helplessness, hopelessness and despair regarding what was available for themselves and under-fives/families they worked with. This was reflected in past findings (Zeanah et al, 2006; O'Neill et al, 2016). Participants transferred and projected these feelings into me and there was no doubting the weight of their anxiety.

Previous studies referred to the benefits of having space and time to share anxieties and to think about complexities of the work. It was deemed of great benefit to be able to talk through challenges with specialists in mental health (Zeanah et al, 2006; O'Neill et al, 2016; Williams et al, 2019). My participants talked about these aspects in terms of longed-for proper communication and pathways between different agencies. There were strongly held

beliefs regarding the benefits of sharing expertise and collaborating minds and theories. The availability of such was recognised as increasing confidence and reducing anxiety.

Case discussions have become an integral and valuable part of therapeutic and support services' work. I suggest pragmatic and/or functional reasons for supervision and/or work discussions are likely to dominate. Professionally-anxiety-provoking and/or frustrating aspects are less likely to be thought about in terms of processing projections and/or countertransference but rather may be considered part of the work.

Bion has written about the importance of others' bearing witness to one's experiences (1962) which seems important and relevant here. I believe this is not just so for clients but equally for professionals in the melee and malaise of an emotional arena. My findings reflect the importance of sharing the burden of emotionally taxing work which work discussions/supervisions could do better. It is not only about support for professionals which, may be incorrectly dismissed as unnecessary because they are a trained workforce or, something to take outside of work. Importantly it is to inform and aide direct work.

Multi-discipline discussions can allow valuable cross-pollination of models, knowledge and support. This was reflected in previous studies (Zeanah et al, 2006; Williams et al, 2019). In my study participants voiced frustrations regarding inaccessibility of other disciplines and minds, particularly mental health support and expertise.

It is evident frustrations build up, are stored internally and become manifest via behaviours/enactments, e.g. splitting, displacement, omnipotence, avoidance. Communion and exchanges with other minds are valuable for both conscious and unconscious aspects of individuals, the system and within the work. Other minds are particularly important in the understanding unconscious and/or somatic behaviours/events (Zeanah et al 2006; O'Neill et al, 2016). My observations and interpretations of participants' material showed unconscious influences.

There was a shared anxiety amongst professionals not wanting to stir up expectations in families. Whilst past studies did not consider ideas of psychic defences, they did record findings which, I believe, demonstrated evidence of them, e.g. omnipotence regarding medical models (Zeanah et al, 2006) and avoiding being explicit about study aims (Alakortes et al, 2017). My participants did not to want to raise hope in parents/families that their infants' difficulties could be resolved when they themselves felt hopeless. Without valuable, reliable and available support and containment, professionals were left feeling isolated and their anxiety increased.

Zeanah et al (2006) did not discuss notions of disgust raised in their findings. I suggested indications that certain aspects of work are difficult to think about and/or hold in mind. Being alerted to internal disgust, guilt, anger or blame is, understandably, challenging. Disgust did not come through in my study however participants conveyed a wide range of anxieties. They also conveyed aspects of the work which were difficult to face and/or have certain conversations about. Such feelings needed to be put out of professionals' minds and kept away from children/families.

Prejudices are very difficult to think about and can often be unconscious. For the Balint group students, they found containment for their pre-conceptions and/or unconscious prejudices (O'Neill et al, 2016). Students seemed more able and available to empathise with their patients, and were relieved, when provided with a safe space to explore their anxieties. They developed questioning minds: challenging internal stereotypes and super-ego authorities. Prejudices were not something my findings explicitly sought to think about. However the way my participants conveyed different outcomes could result for families, dependent on models of under-fives and/or resources available, could conceivably be thought about as prejudicious to under-fives/families. There are multiple hidden, subtle and/or nuanced ways to consider prejudices. For example, inter-team feelings and thoughts from my

participants may be related to some pre-conceptions and/or prejudices regarding different disciplines perhaps.

Herein is evidence for the need of, not only a container, but a thinking container. Alpha-function (Bion, 1962) and mentalisation (Fonagy & Allison, 2012), the capacity to think and reflect, are required.

My participants seemed to seek these opportunities however their experience is that the way peer/group supervisions operate currently do not allow for cross-/inter-agency thinking routinely.

Integration

Research from my literature review and findings indicated integration was not about whether services operated within one organisation or whether independent separate services existed. Rather it was linked to better working relationships, improved communication and the avoidance of fragmentation, feeling isolated, overwhelmed and confused.

I suggest Stern's (1985) importance of integrated selves to infants is no less important for adults/professionals.

Previous studies showed professionals wished to retain professional identity and integrity of their own vocation or discipline, at the same time as being aware of the value of difference, diversity and the variety of ways of thinking (Zeanah et al, 2006); Davidon et al, 2012). My participants talked about difference and sameness across disciplines.

Tensions were also evident between difference and diversity and, shared by my participants and past studies (Davidson et al, 2012; O'Reilly, 2010).

Crehan's & Rustin's (2018) explorations of anxiety related to explicitly addressing difference and diversity in work discussion groups are echoed by my findings: In practice such tensions and complexities in this area are extremely difficult to think about.

Psychoanalytically, these difficulties are loss of self/identity and/or fear of becoming absorbed into another dogma. Another difficulty is how to manage thinking about these issues without individuals feeling vulnerable, persecuted and/or defensive. I do think these aspects require commitment and thought because of the way they can be so insidious and unseen and impact working relations with colleagues and children/families.

A frequent tendency is splitting as shown through past and present data. Davidson et al (2012) cited the apportioning of blame by the person/team, believed to be in deficit, referring to another team as responsible. My findings showed evidence of blame and/or envy where other teams/personnel are felt to possess and/or withhold something experienced, by the perceiver, as a deficit or absence. Collusions and conspiracies to keep out were evident.

Conflicts regarding different team priorities were cited by my participants and past studies. These could be acknowledged and uniting factors on one level. Empathy and understanding were shown and associated with workload, pressures and capacities as my participants demonstrated.

What is difficult to integrate is that both could be true: that someone else has something that could help; and that they are working equally as hard and have their own anxieties, deficits and needs.

My participants expressed that no one profession/service were able to do everything, e.g. the jigsaw puzzle idea. Previous studies showed the benefits of incorporating other and/or cross-pollinating models (Zeanah et al, 2006; Davidson et al, 2012; O'Neill et al, 2016). There are difficult balances to strike in order that professional identities remain distinct whilst benefits are maximised.

Tensions may be considered systemically as sibling-like, e.g. professional rivalries. Management and/or hierarchy may be experienced in terms of parental-authority, e.g. macro-/micro- management. Tensions may be linked with borders and what is permeable and/or

impenetrable, e.g. what can be helpfully taken in, or not: inter-disciplines and/or -team/service, professionals-to-clients and internal/external borders of infants'/families' and professionals' minds. Conflict, difference and diversity are multi-faceted within all relationships of the professional-family-system. These tensions are understood by child and adolescent psychotherapists.

Change

Another aspect of commonality between reviewed literature and my own was the reference to change. Changes and transition to new policies, practices, interventions and/or network/service models with the disruption they bring are understandably challenging and take time. Landscapes inevitably change.

Even when benefits are overwhelmingly recognised, via pilot projects or evidence-based research, in practice work-culture and the investment of time, practice and/or sustained commitment can be hurdles to implementing change (O'Reilly 2010; Davidson et al, 2012; Williams et al, 2019). My participants referred to the same issues.

Singletary (2015) described management of stress response systems. Although Singletary's paper is concerned with ASD it is helpful in understanding the autonomic stress system. Homeostasis is universally desired and disturbances to internal equilibriums, e.g. uncertainty and change, can unsettle and be resisted.

Often these disturbing and/or disruptive experiences are reframed into pragmatic concepts and/or decisions. Factual and concrete concepts, e.g. the use of language around frameworks, models and inter-agency pathways, can feel comforting and reassuring. It can feel reassuring to believe we know and understand: a frame to affix to when our internal emotional compass has been discombobulated.

Despite what we might know about any benefits associated with change, Freud's (1914) commentary on repetition highlight difficulties which need to be worked-through regardless. I suggest these internal psychic hurdles and relational complexities may be minimised and/or overlooked in professional systems and everyday working with under-fives/families.

Change may impact professionals in a number of ways by putting them in touch with need and dependency as shown in my study.

Staff retention and turnover were mentioned by previous findings (Davidson et al, 2012) and raised by my own. These changes can be very disturbing and there can be additional demands on remaining staff. There was repetition amongst studies pertaining to feeling overwhelmed and/or working beyond their remit (Davidson et al 2012). My participants raised the same issues. Such issues put individuals in touch with survival and one's capacity to function and belong or remain in a system.

Changes which were considered helpful were similar between previous studies and my own: more staff, more funding, more resources, more training, more time, and so on. O'Reilly (2010) suggested more money was a common cry from teams in crisis. Hood (2015) highlighted complexities cannot be simplified. My participants referred to issues not being resolved by more funding and/or more training.

The tension within change involves the ebb-and-flow of internal relational factors. I understand them in Kleinian concepts of the paranoid-schizoid and depressive positions and the movement between anxiety and psychic reality (1957). It is a real challenge to reflect on ourselves and our relationships with others, especially when caught up in professional tasks.

Tales of the unexpected

I was most taken aback by an unexpected level of animosity towards CAMHS within my study. It was important for me to understand this aspect of my study as researcher, child psychotherapist and as a CAMHS' clinician. Two aspects seem important to discuss: my role as interviewer-as-container; and reflections on relationships between CAMHS and other services.

Interviewer-as-container

My countertransference when participants expressed animosity towards CAMHS included a sense of something unwanted and unpleasant deposited into me and, also a maternal-like upwelling to nurture something important gifted to me. This put me in mind of Meltzer when he described 'the need for an object in the outside world that can contain the projection of it—in a word…"toilet-breast"' (1967, p20). I suggest something of participants' experience with CAMHS became unconsciously activated and enacted by participants with myself.

Unexpectedly, as an interviewer I had inadvertently and unconsciously become a container. Particularly important was my capacity to take in painful and/or uncomfortable feelings, thoughts and experiences (Bion, 1985). I had not imagined this outcome before my reflections through thematic analysis and of my countertransference.

This demonstrates the need of a container for each of us. Whilst I am generally aware in my clinical role with children and families, as interviewer this took me by surprise. I too can get caught up in different, often conflicting, internal and external agenda. I need time to reflect and other minds to help me sustain sound thinking. It highlights the importance of reflection and reflexivity.

Other thoughts on my interviewer experience relate to my membership of CAMHS. Part of the participants-and-self joint agenda, I would argue, was that we were all contributing to something we might understand together and collectively bring about improvements to under-fives' services. There are multiple ways to think about this relationship with my participants.

Perhaps what may have gotten enacted was an unconscious retaliation or attack towards CAMHS' via me, or against me as an agent of CAMHS' being perceived/experienced as coming with a hidden agenda. Perhaps my questions were provocative in a way I had not considered. In any of these interpretations, participants may have unconsciously responded to an internal drive to attack and/or defend against uncomfortable issues I brought to the fore. The interviews perhaps provided unconscious opportunistic agency for participants to protest against me-as-CAMHS or me-as-systems. In a more straightforward way I was also being asked to know and bear witness to participants' difficult experiences (Bion, 1962).

I think use of me in any of the above ways can be understood via psychoanalytic object relational theory. They highlight professionals are human and need to vent, work through and understand their experiences. Perhaps the opportunistic nature verifies comments regarding a felt lack of containment and mentalisation in their everyday line of work. It would be difficult to know where and how to think about such inter-agency issues but to ignore they exist would seem to add to any injustices. It seemed on one level participants seemed aware that talking about difficulties and/or issues is cathartic as mentioned by more than one of them. This brings me to reflections on inter-relations.

Reflections on relationships

Psychoanalytic and systemic thinking recognise relationships within/between professional systems as often replicating and/or enacting familial relationships, e.g. teams/colleagues as siblings, authority/management as parental authority as mentioned. It is also possible to consider functionality systemically. For example, a team or services around a might enact symptoms of dysfunction and/or functionality represented within those family/parent-infant relationships with whom they work.

Anxiety-provoking feelings and systemic dynamic difficulties without understanding, or reliable mentalisation and containment referred to, can prevent creative thinking and transformative progress. For example, 'I don't refer' or 'we don't see under-fives' resulting in the capacity for individuals/services to ostracise and/or ex-communicate each other. The dysfunctionality which participants were frustrated and distressed by was shocking to discover. If these relationships could be understood psychoanalytically, it could provide hope to avoid repeating dysfunctional enactments and/or inter-relational confusion or stagnation.

I wonder too about the relationship with protectionism. My participants referred to a sense that services/agencies 'up the ante', presenting an idea of protecting one's own and/or defending against others/outsiders. This may be related to a sense of needing to protect under-fives as well as an internal preservation system for oneself/team.

I was put in mind of Canham's (2002) 'Group and Gang States of Mind'. Through operations within the paranoid schizoid and depressive positions, gangs, protection rackets and/or saboteurs can become mobilised internally and played out externally. Such conflicts can materialise in scapegoating and/or blaming and shaming which was evidenced in past literature and in my study. Perhaps CAMHS has become a scapegoat for broader difficulties in the system.

The way services operate and/or relate to each other would seem fundamental in understanding and addressing difficulties. I suggest there may be a direct link between a held belief CAMHS do not take under-fives referrals, a held perception that few under-fives referrals are received and the relationship between CAMHS and other agencies. I think ideas of blame and/or responsibility become distractions from thinking and exploring of systemic-related issues.

Psychic anxiety/pain is understandably defended against. Steiner (1985) talked about a 'cover up' of psychic pain where perversities can exist. This came to mind when my participants spoke of avoiding certain aspects of the work with families. This seemed so contrary to the compassionate nature and passion for the work which I know my colleagues have and participants clearly expressed. It cannot be how professionals prefer to work and feel.

I wonder if there may also be something cultural about this aspect of communication, which means British or Western cultures find difficulty in challenging potentially confrontational or conflicting issues in straightforward ways. Stereotypically adults from these cultures find it difficult to identify acceptable ways to complain or criticise others and/or authority. There is something almost martyr-like in putting up with something uncomfortable rather than address it. This requires further exploration as I am generalising.

It is possible inter-agency/-CAMHS' angst may in part account for differences in perceptions whether under-fives experience mental health difficulties or not. Perhaps other services are easier to work with as my participants expressed and under-fives traverse other systems avoiding CAMHS. It seems difficult for some to imagine the most vulnerable population of our community are the start of a mental/emotional health continuum we all find ourselves on. These systemic and systematic issues have serious implications for

professionals' inter-working relationships, and experiences and outcomes for children and families.

It cannot be healthy for professionals to harbour resentment and/or not be able to have conversations they need to have with families and each other. Their despair conveyed they desperately want to be able to do the work they are passionate about. It cannot be acceptable for under-fives/families to be subjects of whims and/or dysfunctions of a system to which they go to for help and support. I suggest my findings highlight professional blind spots which need to be understood in context.

Steiner's (1985) paper 'Turning a Blind Eye' alerts of the complexities of authority/dominant dogma and functionality; the capacity for individuals to be blindsided by something they are a part of; and how difficult it is to challenge dominant internal organisational states and external organisations.

I suggest grievances and wish-list items found within Integration and Dependency indicate inter-agency professional-sibling rivalry, envy, resentment and frustration. These were apparent between varieties of agencies in previous literature. My findings have drawn attention to confusion pertaining to CAMHS and infant mental health.

I had under-estimated some of the unconscious and/or systemic influences. Perhaps I might have expected repeated themes of Anxiety and Integration, for example. These are pivotal aspects of relational dynamics. However I was taken aback by the degree to which they are at work, the impact on professionals and the working dynamics of infant mental health.

I feel these findings are directly related to my pre-study confusion regarding referrals of under-fives and what happens to mental health/wellbeing difficulties they have in our locality. I believe the inter-agency professional family-/sibling-like difficulties are a factor but there are also others. Child psychotherapists need to better communicate their role to

colleagues/agencies. In this particular context that responsibility falls to me. Another issue appears to be related to the different ways professionals perceive infant mental health and/or the different ways under-fives/infants are perceived as individuals and a population.

Curious tales

The Curious presented alternative ways of thinking about this vulnerable, mostly non-verbal, population in society. This brings me to suspicions I had had regarding what happens to under-fives and/or under-fives' mental health in the minds of professionals. Previously I had been unable to put a hypothesis to my random thoughts. The presence of different representations of infants suggests infants can occupy places and/or become categorised in the minds of adults. As stated, contrary to its minor theme status, it is major in gravitas and seems crucial to understand, or at least acknowledge or notice.

Whether hidden or missing, revered or feared, and/or unclaimed, the different imaginings of infants, the different placement they might hold in minds, seemed significant. Steiner's 'Seen and Being Seen' identified the importance of being seen and known to the infant's emotional development and integration of self (2006).

Young-Breuhl wrote about 'childism': a 'complex prejudice' that can function to eliminate, sexually exploit, and/or erase identity of children, reflecting 'all three characterological defence types' which are 'obsessional, hysterical and narcissistic' (2009, p251). I wonder about the different babies being representations of complex prejudices and/or preconceptions.

It is challenging and uncomfortable to consider power dynamics between ourselves and infants, and uncomfortable to imagine under-fives imbued with unpalatable or intolerable feelings of their own. Hurley in 'Her majesty the baby' exemplified the difficulties and complexities related to these dynamics (2017) e.g. omnipotence, ordinary narcissism.

Internal prejudices are complex and multi-layered. Wider societal views are likely to resonate with intergenerational sensibilities, cultural idiosyncrasies and/or personal political views.

Lieberman et al's (2005) 'Angels in the nursery', a complementary paper to Fraiberg et al's (1975) exemplified benevolence can be influential too. I think the presence of counter-papers serves to evidence how difficult, challenging and unpalatable these emotive issues are to hold in mind, and a need to be hopeful.

'Whose baby?' to 'claiming the baby' appeared to encapsulate many of the issues already discussed. The baby we have is the baby we need to attune to: meeting, claiming and getting to know the real baby (Alvarez, 1992, Baradon et al, 2005). I suggest this is also true for professionals/services/agencies.

I suggest the somewhat free exploration of my study presented alternative ways under-fives may be encapsulated and held in mind aside from the norms. This seemed helpful and enlightening inasmuch as it brought out aspects not always in the forefront of professionals' minds. It can be hard to reflect on cultural and societal aspects of children because professionals/adults are part of the culture and/or society. This study has revealed some of these other perceptions.

Beforehand I had wondered about the different ways under-fives might be held in mind by professionals but had not been able to conceptualise it sufficiently in relation to anecdotal evidence of thoughts about under-fives mental health, referrals to CAMHS and/or the need for a service for this population. I feel explorations have opened-up some of what is hidden or unspoken. As with 'Angels', preconceptions need not necessarily negatively affect under-fives and families but it is important to give credence to their presence.

This is not about falling into judgment ourselves but rather understanding and noticing these aspects of the work. Participants drew attention to the reason it is important to understand, because they can impact pathways and/or outcomes for infants/families.

My findings suggest there is a real need to identify and get to know under-fives and to really see/know them and, further, really get to see/know the professionals/services we have so we are able to recognise, communicate and work effectively with each other. Systemic issues and/or gang states of mind as well as issues of being seen/unseen, I suggest, are alive within my findings and impact how professionals/agencies work together and outcomes for infants/families.

Reflections

Reflections will be presented via a familiar mechanism when working with infants and families: 'What went well?' and 'What could be improved?' I will end with conclusions of clinical implications and future application.

What went well?

I brought together research from previous literature and novel data to think about and analyse professionals' experiences of their work with under-fives.

My study successfully provided an opportunity for professionals to share views about their role, under-fives' mental health and wellbeing, and their experiences with families and colleagues/agencies. They have shared their narratives, frustrations and insights.

The semi-structured interviews enabled qualitative data to be gathered and reflexive thematic analysis has provided coherent themes to be able to think about findings.

Despite interviews being short and ruptured by resource limitations, the depth and breadth of what participants shared and conveyed seemed extraordinary. The study seemed to have provided an unforeseen opportunity of containment and to bear witness to professionals' experiences. Containment and bearing witness are important in the role of psychoanalytic psychotherapists. This study seems to have revealed a need in professionals working with difficult primitive projections from infants and families.

As a researcher and child and adolescent psychoanalytic psychotherapist, the study has also enabled me to understand aspects of the system and field of work I had previously not known.

I feel it has been helpful for me to understand the different ways under-fives are held in mind by professionals and hopefully will prove useful to other child psychotherapists and disciplines.

Knowing some participants prior to interviews, I believe, had both pros and cons, and the impact of this on the data cannot be known fully by me. Candidness may have been enabled or restricted.

What could be improved?

Undoubtedly this is my study through my lens. It seemed likely that, as a psychotherapist, I would have interpreted relational aspects within the data, and the themes reflected this. I will not labour this point as it has been mooted. I acknowledge another child psychotherapist or another researcher from a different discipline would likely have come up with alternative findings. Nevertheless I feel my study will provoke dialogue and understanding, which is a valuable aspect of research.

Although questions were intended to invite open and explorative expression, other questions may have produced different narratives and outcomes. One question specifically

invited experiences regarding barriers/obstacles and focused on improvements. This line of questioning may have influenced a tendency towards finding fault and/or error and inadvertently set-up defensive internal mechanisms. It may also not have invited celebrations of achievements explicitly.

It is also possible that the limited questions and time missed other things which might have been shared otherwise. At the end of my questions I offered a completely open invitation to share anything else participants might have wanted to say but this may have been too little too late in the interview. Despite the positive of gathering data, the disruption of turning the tape over, during interviews, undoubtedly had some impact on interviews.

I think it important to note I did not know what I did not know at the outset and feel confident my questions were unlikely to have led participants to anything preconceived. Nevertheless I acknowledge participants were limited to my questions.

I tried to attract professionals from across a wide range of disciplines. It was disappointing not to attract an even distribution of disciplines and/or a broader professional diversity. My study did not manage to recruit nursery staff, nursery nurses, or other education professionals in early years, Early Help, GPs, Safeguarding or voluntary organisations. Inclusion may have arrived at more thorough and/or other findings. As also may have, the identification of age, gender and/or ethnicity perhaps.

When it came to considering analyses of the themes, I noticed how difficult it was to uniquely separate them. Such complexities are understandable because different aspects of human nature and psyche understandably are related. My psychoanalytic way of thinking does not fit easily into boxes/themes either. I have tried to explain how there is overlap and some parallels between themes by way of mitigating any potential confusion.

Due to my study being a doctoral project there were inherent limitations: for example, time constraints, number of participants and locality restrictions, and my being researcher-interviewer-and-analyst. Inevitably this has impacted on the generalisability of my findings.

Had there been ways to mitigate and/or proceed differently without the above constrictions the data findings may have developed otherwise. Notwithstanding this, significant aspects of the data have improved my understanding and I believe still have clinical application.

Researcher reflexivity

The research process has brought to my attention some personal internal conflicts regarding my researcher-self and my psychotherapist-self. As a novice researcher it is evident that I have struggled to assimilate and/or integrate these roles.

Regarding the emotional-heat I encountered during interviews, for example, I was aware of feeling somewhat disarmed and resisting responding how I might as a therapist. There is clearly a difference between an interview and a therapy session however perhaps I had not sufficiently considered differing aspects prior to embarking. By contrast, I did facilitate dialogue demonstrating a capacity to listen and hold narratives.

It seemed I had an unconscious sense of some incompatibility of the different selves and roles which, in hindsight, resulted in missed opportunities for cross-fertilisation and further immersion in the data set at the interview phase.

Vacillation between these different selves is likely to have impacted my study in ways which were not easily spotted without hindsight. I think I held quite a rigid perception of research tasks as though there was a *to do list* to accomplish. Whilst true in part, my difficulty to integrate meant my psychoanalytic psychotherapist-self, who is generally free to be curious, meander about meaning and interpretation, became either marooned or cut-off at

times. This is important to note because it may have resulted in some impoverishment in a rich data seam.

Another role I held was that of student. It seems perhaps I carried a sense of impoverished status. Is this what became enacted when I could not source a recording device with more capacity, which would have avoided turning tapes over? I remember feeling somewhat embarrassed, initially, and subsequently I accepted this was something which happened during interviews. My cultivated complacency perhaps minimises or denies a power dynamic, especially I consider embarrassment signalling shame or humiliation. This psychoanalytic reflection suggests I may have brought unnecessary impoverishment to data richness. By its nature a disruption is disruptive. Focused analysis on process rather than content might reveal more.

Regarding the choice of methodology, I believed Thematic Analysis was a good fit with my psychoanalytic lens and the narrative experiences I wanted to attend to. This still feels right because I was focused on the content and Thematic Analysis enabled me to do this. On reflection, I would have been possible to use Thematic Analysis differently, and/or another form of methodology, focusing on process which may have better captured the unexpected emotional-heat and/or the unexpected data. My findings might benefit from being explored differently in an alternative future study.

Returning to the emotional heat, somewhat, I noticed I experienced a huge sense of responsibility regarding narratives conveyed and entrusted to me. What was exchanged mattered, and does matter, to me. I believe I contributed to the authenticity of the moments in the interviews and that some of the candidness from participants related to this. I suggest my participants were likely to have felt heard and attended to as they shared experiences and issues they feel caught up in.

Conclusion

Clinical implications and future application

There are a number of clinical implications apparent from my study: systemic factors; under-fives being seen and known; professionals being seen and known; and system clarity.

Calls for better communication and improved inter-agency working are not news, and it is an ongoing endeavour for many NHS and local authorities. Poor quality communication and inter-agency working is quoted all too often by serious case reviews (SCRs) as a major contributory factor when a child has died. This study has revealed the presence of important underlying relational, unconscious and/or systemic factors which could prove important in understanding and improving inter-agency working.

Findings suggest there are fundamental relational dynamics, internal conflicts, different training/disciplines/models, individual experiences and societal/cultural influences, which mean under-fives can occupy different places in professionals' minds. Narratives indicate such factors impact system relations as well as outcomes for under-fives and families. All relationships would benefit from professionals and services being mindful of factors which can get in the way of being able to see and get to know the under-fives and families they encounter in any moment.

I argue the impairments of under-fives being seen or not-seen also apply to professionals. The place disciplines and services occupy in professionals' minds become filtered through influential, and I would argue often unconscious, factors meaning other professionals/services can have different guises attributed to them. The result appears to be that they are seen through a veil of relative perception and/or unseen. This is evidenced by my findings of the animosity, confusion and mystery between disciplines/agencies. For example, who is doing what where and/or feelings of collusion and conspiracy. My findings

suggest not seeing and not understanding the underlying relational aspects result in a Babel-like system: unsatisfactory for professionals to work in, trying to do the vocations for which they trained and are passionate; unsatisfactory for policy-makers/commissioners/managers trying to offer effective services and a contented sustainable workforce; and unacceptable for under-fives and families being failed.

Under-fives appear to be falling through a gap. Worse than that it seems, they are falling unseen through an unseen gap. This leaves professionals who perceive a need, frustrated because they cannot access expertise they need for themselves and/or the services/interventions which they believe could help under-fives/families they work with. This seemed particularly so for mental health expertise and knowledge. I would not have been able to articulate this prior to conducting my study. It now seems a clear understanding which I have gained.

I think it is incumbent upon different disciplines to be able to convey their work to other disciplines/services, and upon each to be curious about other skills and expertise available. I became clear that I, as a child and adolescent psychotherapist, have not satisfactorily accomplished this within my team. Findings showed confusion amongst multi-disciplines within CAMHS and amongst external disciplines/agencies as to the contribution psychotherapists have to offer under-fives' mental health and their families. This understanding was hugely disappointing but can be relatively easily solved by psychotherapists finding opportunities to speak about and demonstrate their work.

Child psychotherapists can offer individual/group clinical supervision, intra-/inter-service consultation, assessments, and direct clinical psychotherapy with parents/carers-and-infants, children from 0-adolescent and parent/family work. With the focus on relationships and relational dynamics it is adaptable, flexible and applicable to the everyday whether, professional-to-client, professional-to-professional and/or service-to-service.

There are training opportunities of infants' internal worlds and psychic development to complement other discipline views.

> *It offers a theory of mental development, combining contemporary psychoanalytic theory, infant and young child observation in naturalistic settings, and the expanding field of early clinical interventions ... including discoveries in the field of neuroscience* (Rustin and Emanuel, 2010, p1)

There is a huge, largely un-tapped, potential for more containment of parents-and-infants/children and of professionals/colleagues. I believe containment is, mostly, understood in terms of the work with children and families. However with regard to professionals and how it might transform staff retention and/or nurture practitioners as they nurture clientele, its function seems greatly under-valued.

I think it is also incumbent on the organisation to ensure those within the system understand what is available. This appears not to be the case for the professional participants in my study. Either CAMHS do serve under-fives or they do not. There are different ways to serve under-fives' mental health needs which is evident in different areas. For example, some have separate/dedicated services for under-fours e.g. London, and/or under-fives e.g. Bristol. As stated, the books 'What Can the Matter Be?' (Emanuel and Bradley, 2008) and 'Psychic Hooks and Bolts' (Pozzi, 2003) describe work with under-fives within the Tavistock Clinic. Looking beyond this locality and at different inter-agency operations may be able to offer insight, perspectives and solutions to each other.

Pragmatism, practicalities and resource issues are real and need attending to too. Participants from my study have conveyed there are other factors, equally important, which may offer an holistic three-dimensional approach to achieve effective operations. It seems too often that the pendulum swings between managing risk and preventative work. Surely they do not need to be mutually exclusive because when this is the case some element of improving the human experience is missed out.

An important issue about these findings is that they are not about blame or shame. My study has revealed ordinary human states of mind shown within certain themes, some of which echoed previous findings. I would feel I have failed my professional community if my conclusions are felt to be criticisms or persecutory. Rather they are observations of the human condition as verified by my professional participants' narratives and experiences. None of us are immune to primitive anxieties. As Luyten (2015) and Crehan and Rustin (2018) have pointed out to really look at difficulties and issues is challenging and takes courage. Collective transformation can only happen collectively.

Participants have conveyed they seek real dialogue, inter-agency communication and consultation in a way where borders of knowledge and expertise are more permeable; for pathways are reliable and lead somewhere meaningful; and each discipline is valued, understood and accessible. I think in the same way we try to support children/families to understand damaging and/or painful relational dynamics as sensitively as possible, we could afford to put the spotlight on systemic relational dynamics.

More research would be required to be sure of the broader reach of my findings. I suggest as evidence of the human condition they are likely not to be unique. I am hopeful my study may provoke useful dialogue in my locality.

In the course of my study, I have felt shocked, unsettled, responsible, afraid, moved and privileged. Participants have shown these are the felt transference and countertransference experiences of professionals working with the mental health and wellbeing of under-fives and their families. The gravitas of the task is clear for all involved: professionals, under-fives and families. Before being sanctioned, the study had a profound and immediate impact on my practice: I am more aware of speaking to observations of network/system function, inter-discipline/-service relations, and primitive states of mind in all of us; I participate in regular shared learning opportunities to keep alive child

psychotherapy's team contribution and the infant's voice; and, with support of management, I offer regular group/team reflection. It was impossible for me not to respond in these ways. I hope for broader clinical application once I am able to precis findings and share them within the locality of the study as promised at the outset. It is not possible to un-see what is seen or un-know what becomes known. Primitive states, internal and external dogma, and defended perceptions are challenging but need to be navigated in order not to continue turning a blind eye.

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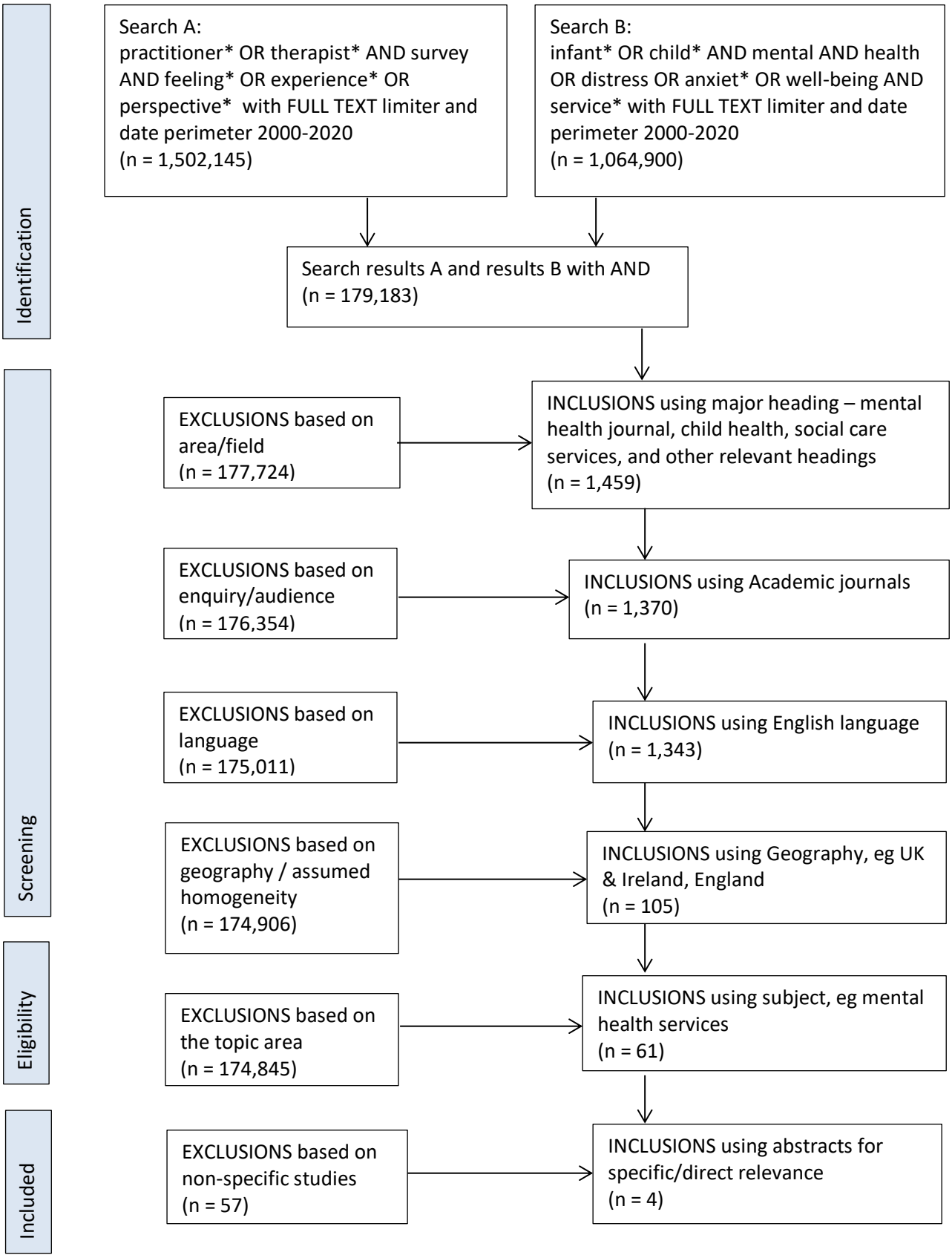
Appendices

Appendix I Prisma flowchart for 1/11 conducted searches



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Appendix III Public facing documents (PFDs)

Recruitment Introductory Leaflet

Doctoral Study: **What needs to be understood by a child psychotherapist working within a CAMHS setting when planning a mental health service for under-fives to maximise successful uptake?**

I am Jennie White, a Child and Adolescent Psychotherapist in doctoral training, working in Bournemouth and Christchurch CAMHS (Child and Adolescent Mental Health Service) since 2015. I am conducting a study into what needs to be understood by CAMHS when providing for the mental health of patients under five years old, in order to meet their needs and for successful uptake of the service. This study hopes to be beneficial to commissioners, practitioners and, most importantly, to put patients' in touch with services they need.

I am seeking volunteer participants willing to be interviewed regarding their practice and experience. The semi-structured interviews will last approximately an hour and may be conducted in person or by zoom-business.

If you would like to participate please contact me. Please note any initial contact does not mean you are committing to taking part and will not be contacted again if you do not wish to participate. Initial contact will enable me to explain the study more fully and provide you with an information sheet.

Thank you

Jennie White
Child and Adolescent Psychotherapist in Doctoral Training
CAMHS Shelley Clinic, 22 Tower Road, Bournemouth BH1 4LB
01202 646300
jennie.white1@nhs.net

Participant Information Leaflet

Doctoral Study**: What needs to be understood by a child psychotherapist working within a CAMHS setting when planning a mental health service for under-fives to maximise successful uptake?**

You have been given this information leaflet because you are thinking about taking part in this study. This information sheet describes the study and explains what will be involved if you decide to take part.

Who is asking me to participate?
Jennie White a Child and Adolescent Psychotherapist in Doctoral Training, working in CAMHS Shelley Clinic, 22 Tower Road, Bournemouth BH1 4LB, 01202 646300. As practitioner researcher I will undertake all aspects of the study.

What is the purpose of this study?
Clinic statistics show a disparity of age across referrals to CAMHS, where I work in my placement: the majority of which are adolescents and latency children. This has made me want to understand more about under-fives' mental health in the Dorset area. I have anecdotal evidence of practitioners having concerns in this area and I wish to gather together and analyse practitioners' thoughts and opinions regarding their experience and expertise in this field, whether working directly with this population or, commissioning and providing services for them. I hope your contribution will provide some insight regarding what would be important to understand in order for the mental health needs of under-fives to be met and for commissioners and practitioners to have successful uptake of resources.

What can I expect?
You will be interviewed by me for approximately one hour. The interview will be semi-structured so as to provide some focus and some freedom for discussion, and will be audio-recorded.

What approval has been gained to protect me, and information about me, in the study?
I have approval for this study through Dorset NHS Research and Development (R&D) and the Tavistock and Portman Trust Ethics Committee (TREC). These processes ensure I conduct the study within legal and ethical standards. If you have any concerns or queries regarding my conduct you may contact Simon Carrington, Head of Academic Governance and Quality Assurance, Tavistock and Portman NHS Foundation Trust (academicquality@tavi-port.nhs.uk).

How will what I do and say be used in the study?
I will anonymise and disguise any personal information, removing all identifying details. The anonymised information will become the study data, and kept entirely separately from your personally identifying information. Study data will be kept in encrypted files, which only I will have access to. Recordings will be destroyed once scribed, and all other study material will be destroyed after completion of the thesis write-up. Your personal details will be stored and protected according to General Data Protection Regulations 2018 (GDPR).

Is there any risk regarding my personal details?
Due to the limited pool of potential research participants (professionals working with and/or linked to under-fives service provision in the Dorset area) other participants might be aware of your participation. As a small scale study there is a very small risk some identifying features may be discoverable, however, every effort will be taken to ensure confidentiality. I am an experienced practitioner in managing personal information and confidentiality.

What happens to the results of the study?
The documented results of the study will form my doctoral thesis, and may become an academic paper and/or published in relevant academic articles and/or presentations. I would be happy to send you a summary of the results.

Do I have to take part?
No. Taking part in the study is completely voluntary. If you agree to take part, you are free to change your mind at any time during the interview, right up until 28 days afterwards, without giving me a reason.

What are the possible benefits of taking part?
1. It is hoped you will contribute to an understanding of what is required to be considered when providing mental health services or interventions for patients under five years old
2. It is hoped you will contribute to an understanding, and improvement, of patients and their families experience of CAMHS
3. It is hoped you will feel you are contributing to practitioners' experiences in a way which makes the best use of expertise and skills, and limited resources

Study sponsor details
Mr Brian Rock, Director of Postgraduate Studies, Tavistock and Portman NHS Healthcare University Foundation Trust, 120 Belsize Lane, London NW3 5BA, (BRock@Tavi-Port.ac.uk)

CONSENT FORM

Doctoral Study:

What needs to be understood by a child psychotherapist working within a CAMHS setting when planning a mental health service for under-fives to maximise successful uptake?

Study Investigator:

Jennie White, Child and Adolescent Psychotherapist in Doctoral Training

1. I confirm I have read the information sheet which provides details of the nature of the research and how I will be asked to participate. I have had the opportunity to consider this information and ask any questions that I might have.

2. I understand my interview will be recorded, transcribed and analysed for the purposes of the study.

3. I understand my agreement to participate is voluntary and, I am free to withdraw it without giving a reason, at any time during participation and up to 28 days after my interview.

4. I understand any identifiable information linked to my participation in this project will be anonymised and held securely by the researcher. I will not be identified in any resulting publications, papers or presentations produced for the professional doctorate.

5. I understand that, due to the limited pool of potential research participants (professional practitioners working with and/or linked to under-fives service provision in the Dorset area) other participants might be aware of my participation.

6. I confirm I have understood what is required of me and consent to participate in this study.

Participant's name (BLOCK CAPITALS):

Signature:

Designation:

Date:

Investigator's name (BLOCK CAPITALS): JENNIE WHITE

Signature:

Date:

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

Post-study information

Doctoral Study: **What needs to be understood by a child psychotherapist working within a CAMHS setting when planning a mental health service for under-fives to maximise successful uptake?**

Unexpected concerns or feelings may have arisen for you from the study. If you would like to speak with someone about these, please note the following resources are available to you:

- **Your supervisor / line manager**

- **Care First**
  Care first provide online or freephone counselling at any time night or day to DHC staff. For free, confidential advice and support call 0800 174379 or access www.carefirst-lifestyle.co.uk/ (login: dhuft, password: wellbeing). Face to face counselling is also available on request. Every call is answered by a Care first counsellor, accredited to the British Association for Counselling and Psychotherapy (BACP). Care first counsellors provide support for anything you wish to discuss from bereavement, relationship breakdown and bullying to changes at work, pressure, stress, workload and illness.

Also if you have any concerns regarding my conduct over the course of this study, I would welcome an opportunity to discuss this with you: jennie.white1@nhs.net / CAMHS Shelley Clinic 01202 646300. You can also, at any point, discuss any concerns regarding my conduct or other aspects of the study protocol with Simon Carrington, Head of Academic Governance and Quality Assurance (academicquality@tavi-port.nhs.uk)

Appendix IV Semi-structured questions

Doctoral Study:

What needs to be understood by a child psychotherapist working within a CAMHS setting when planning a mental health service for under-fives to maximise successful uptake?

Semi-structured interview guide

What comes to mind when thinking about 'mental health of infants/under-fives'?

Do you believe under-fives experience mental health difficulties?

How do you consider the mental health of under-fives in your profession?

Do you encounter barriers/obstacles when thinking about mental health for young children?

What comments could you make about multi-agency / inter-agency working?

Do you encounter barriers/obstacles when working with families/carers or multi-disciplined professionals in your professional endeavour?

Do you have worries regarding talking about mental health with the population you work with?

What do you believe is important when considering introducing a psychological treatment?

Have you been involved with any projects introducing interventions? If so, what could you tell me about that experience?

Is there one thing you believe could improve understanding the mental health of under-fives?

Is there one thing you believe could improve multi-agency working together?

Appendix V Coding examples, phase 1 & 2

	Coding phase 1 – associations?	Coding phase 2 – meaning?
1. I think the main thing I'd be thinking about is, particularly the relationship between the child and parent, attachment, as well as other behavioural issues: in terms of sometimes seeing some sort of ADHD behaviours in a young child; but mainly it's about the attachment relationship.	Relationship Attachment Behaviour – still possible to pull out behaviour as though it is separate – how can behaviour be separate to thought/feelings? Attachment relationship	Relationship recognition Attachment Behaviour Mainly, 'attachment relationship'
2. Yes; Often it [mental health difficulties] presents more as behavioural difficulties. [what about an infant/under-1?] I think, certainly, you can see difficulties in how the infant deals with distress and the care-giver's ability to help them manage that distress; and you can see other difficulties, in terms of how the mother or father and infant are relating to each other.	Behaviour = mental health of individual Baby's management of stress/distress and parent/carer's ability to support them Relationships	Behaviour = mental health difficulties Non-verbal communications/behaviours = not so easy to name the non-verbal cues/communications Relating is key
3. I think it's recognised as being a significant issue; I think it probably it is, in terms of the way clinics are set up, it's very difficult for those [infant mental health] needs to be met because other things crowd it out; if you've got a 16yo who's suicidal, it's very difficult for resources to be allocated to something that's seen as	Infant mh gets pushed aside for other pressing issues, eg adolescents Service isn't set up for infant mh difficulties – set up to manage risk and a service for adolescents/latency children Suicide trumps distressed baby!	Services struggle to attend to mental health difficulties because other needs 'crowd it out' - Not a priority? - Not understood? - Too difficult? - Can't see it? - Non-verbal and non-mobile babies? - Not risky enough?

lower priority; and I think the reason it's seen as lower priority, because although there might be distress there, it's perhaps not life-threatening distress; in terms of externalising behaviours they [teenagers] can do more damage, and so people can get concerned about those risks, but I think it's [the issues] often seen through a, sort of, risk-filter, and it's that 'at risk of significant harm to self or others' [quoting CA1989] that pushes things out; although we know that, actually, if we can get in earlier you can, perhaps, prevent some of those problems later on.	Baby's distress isn't perceived as life-threatening! Not so for the baby – survival?! Risk-filter Early help – get in early idea	Service thresholds seen through a 'risk-filter' Service thresholds more about funding and risk? These are limiters but understood as necessary/significant barriers/obstacles Prevention!!! This doesn't take as much priority even though it's known
4. I think it's that [the risk-filter] that makes it difficult for an infant mental health difficulty to get through screening; you know, if you've got 5 referrals of adolescents, who are self-harming and things, it's then difficult to allocate something that, perhaps, you think, oh a health visitor could deal with that; whereas, actually, there's good evidence that intervening, well, early on can have big dividends, in terms of a young person's journey through life; but I think the difficulty is, if you're going to do that work, it needs investment but you don't see the benefits for 10-15 years really, 30 years, in terms of, actually, if you're	Risk-filter makes it difficult for infant/under-5s mental health to get through screening Assumption regarding HV's capacity Surely, measuring/gauging referrals against each other, isn't the way to think? Surely, each referral needs to be thought about in its own right?! 'Intervening EARLY pays dividends' 10-15 years, 30 years, investment is difficult/impossible to do (politics, budgets, policy changes take time, etc)	'Risk-filter' Competing demands/needs: adol vs u5s; self-harm vs not sleeping; etc Competing demands/needs: infant needs seen as less important …? Or … HV's seen as managing less important issues? Long-term investment needed – trajectory is difficult to hold in mind for commissioners and funding, as budgets change annually and politics have an impact as to how different govts

going to reduce the risk of serious mental illness; I think the demand has increased so much, that that's what CAMHS is dealing with, we are fire-fighting. [changes over time?] When I started about 16 years ago we got the same number of referrals in two weeks that we get in a day now; MDMs used to be, we would read out every referral that had come through that week, discuss them and decide who was going to see them. [have patient demographics changed over time] There's far more young people who are self-harming, now, particularly adolescents.	Risk means fire-fighting – this doesn't work for long-term investment/thinking! Increased referrals! Increased demand for the service! Increase in adolescents! Increase in self-harming!	approach community needs/demands Increased demand overall Increase in self-harming adolescents
5. [multi-/inter-agency working] I'm not sure there's an awful … apart from perinatal services … I'm not sure there's an awful lot of inter-agency work … [what do you think that's about?] Um, again, I think it's that same thing … it's about prioritising resources, really; I think, also, there's not a good tie-up, even within mental health services, between adult mental health where you've got a parent of a young child, and the parent has significant mental illness: firstly in identifying that they have children and then	Multi/inter-agency working is almost non-existent! Quite shocking? Prioritising of resources determine outcomes – quite shocking, again, because surely the individual patient should come first, not what's available?! Not good joined-up thinking or work between adult mh services and children's – this is important when many adults, struggling with mh, will have children! Obvious missing link!	Next to no multi-agency working!? Shocking! Prioritising resources Need to join-up, incl adult services – eg CMHT working with adults with significant mh difficulties who HAVE CHILDREN aren't catered for/thought about?!

thinking about the effect that that's having on the infant's mental health.		
6. No, not when I do; it's not often I see under-5s but it does happen sometimes; but I don't encounter significant barriers; I guess, it's probably because when I get involved that a lot has happened already really, so I probably wouldn't be the first point of contact. [example?] I've seen under-5s where, you know, we're aware there are significant symptoms like ADHD; although we probably wouldn't be prescribing, they might be asking is this ADHD … it's unusual to be looking at ASD in that age-group because it normally goes to community paediatricians, um, potentially it has happened and I'll be asked is this attachment or ASD?	Once seeing patient/families, not so many barriers/obstacles to think with them Limited experience, eg ADHD Unusual to consider ASD for under-5s – what is this about? Under-5s go to community paediatricians – Why automatic?! Are autistic defences thought about?	Not significant number of under-5s seen by this practitioner / certain practitioners by the nature of their field of expertise – this is a separate issue to under-5s not being referred or seen due to other barriers ADHD/ASD usually community paediatricians? Interesting because comm paeds feel out of their depth at times – Conflict when ADHD/ASD seen purely as a behavioural issue? – This is where joined-up services could help each other and relieve pressure points
7. I think it's [the topic/area of infant mental health] increasingly recognised as somewhere we need to be intervening; I think, within the Trust it's recognised, now, we need to be doing more for infant mental health; so there was a meeting last month, you know, about thinking Trust-wide how do we respond to infant mental health, and then what do we need to be doing to intervene better.	Intervening early is a known/given Things afoot in the Trust Recognition of child development being significant! Obvious, of	Increasing awareness of the importance of attending to the mental health of under-5s Increasing awareness of this area needing a trust-wide response – no one service/area/commissioner can do it alone

[sense of what's driving that?] Well, I think, recognition that, actually, in terms of a child's development and early changes are pretty significant, in terms of how the brain develops; if you're not responding, you're doing catch-up later on, um; I think there's also recognition within the Trust that there's been a number of serious case reviews, of parents with significant mental illness have ended up harming their children; and that we probably need to be intervening in those families to prevent harm, really. [thinking about evidence-based drivers, eg 1001 days] I think, Nationally, there's more of a drive, but I think there is a recognition of the potential harm that can be done; SLAM (South London and Maudsley) they've also been looking at that and have set up a new team, the Helping Families Team … well, it's not just for under-5s but does have an under-5s focus service.	course, but taken time, it seems Brain development – more is known If early intervention isn't thought about, then one is 'playing catch-up' later – it's logical!!! Common sense! SCR lessons – prevention Evidence-based drivers New TEAM – like a family hub?	More known about brain development – neuro-development/research – common parlance/Joe Public knows more SCRs important lessons – prevention important rather than too late!? Evidence – shift to thinking more about holistic service
8. Well, I think, you need a good evidence base because if you don't you're not going to get anywhere without some research evidence that it is effective, um; I think you've got to think, can you get a workforce be able to deliver it; how accessible is the training in that	Evidence is important – needs to have proven effectiveness Does the workforce match the need/demand? Cost-effectiveness – how sustainable is a service?	Evidence – training, funding, matching need with service No evidence-base, no funding/support

psychological therapy; and then how sustainable; how costly is it; is it sustainable to deliver, um; and thinking about, exactly, who you're going to deliver it to, you know, what is the threshold for the treatment; but if you haven't got that research base, you're not going to be able to get anywhere really, you're not going to attract any funding.	HAS to be thought about in detail to attract funding!	
9. I guess, in terms of interventions, I was probably one of the earliest people to be trained in EMDR (eye movement desensitisation and reprocessing) here, because I was interested in it; and then it was just about encouraging people to do it .. and … and taking it the Trust structure, as it was then, that it was something that could be used in young people, um; and the evidence-base grew so then it became something recognised that it could be used in the under-18 population; I guess the other thing we started was the Webster Stratton Parenting Programme, um; there was a good evidence-base for that, and we presented that and we did get funding, then, to start delivering that in Dorset, um, that was something we introduced about 15 years ago, and it wasn't happening before; it was about showing there was a need there and then saying there's this evidence-	Evidence Evidence Funding About showing a need and an evidence-based treatment; then costing everything out; running a trial/pilot and growing it	New services/interventions are possible but need: conversations, evidence, detail and time

based treatment that can meet this need, and then looking at the costings for it, and running a trial of it, a pilot of it, and then spreading it out.		
10. [ethical difficulties?] Um, I think … it's probably not an ethical difficulty but, I think, some of my colleagues in adult mental health struggle with thinking about children of their patients because, firstly, they think it might interfere with their therapeutic relationship with their patient; secondly, they're not sure what they'd do with that information; um, and they tend to think, well, the only intervention is to let social care know; and then the children might be taken away, rather than thinking there are possible interventions that you can do to try and help, um; I think, um, in other respects I'm not sure the ethical difficulties are very different to working with other children, really, in a CAMHS setting; if there's a therapeutic need then it's not an issue. [does the non-verbal nature of infants have any different impact/meaning, re: ethics] I think not so much, now that perinatal services have really pushed the whole attachment and delivering interventions for mother-and-baby, um; I think commissioners don't	Some struggle with ethics – others not Prof working with adults, perhaps, have a worry about children interfering with therapeutic relationship Prof working with adults, means children/child mh is outside their comfort zone and expertise – they 'don't know what to do with it' Adult mh profs seem only aware of soc care and ref any unknowns to them Ethics seen as same for children and adults – perhaps, not all think like this? It's about therapeutic need Non-verbal – no concerns – attachment is the buzz-word Idea that there isn't so much of an issue for commissioners, re: ethics/working with young children via parent-work/mother-and-baby-work – this is not the same as really understanding what interventions might appear like for the baby	Idea that children are a mystery to some Idea that children of a patient (in adult services) will compromise clinicians Fear of something being outside one's expertise – don't know who to ask questions of, so don't ask questions?!! Social care = taking children away, for some clinicians! Climate of fear – fear of the child and fear for the child; fear of recriminations from parents; fear of SCRs Perinatal is the key team for under-5s Attachment interventions – not a problem now!?

struggle with it, now, they do see it as … certainly locally I don't think they do [see it as a problem].		
11. [empathy] I think, probably, for people working outside the field, who perhaps aren't aware of attachment and things; you know, it's probably harder to think about it when a child is non-verbal, but I certainly don't encounter that here or in the mental health field. [attachment meaning different things to different people?] I think with professionals within the field [of mental health] there's much better awareness of what attachment is, now, whether that's in CAMHS or wider mental health, or in social care, I think; you know, there's a lot more attachment training now; again, outside of professionals, I think, attachment gets confused with bonding, um, they could well struggle to know what it means; but, certainly, over the last 10 years, I think, in social care there's been a lot of education about attachment.	Non-verbal patient/client not an issue in field of mh but rather those outside of the understanding of attachment – Not sure it's as clear as this!!? Idea of a common understanding of attachment which I don't, necessarily, agree exists!? Better awareness of the word, I agree Attachment training? What does this mean? Confusion between attachment and bonding Attachment training/education has improved – small steps, of course – 'attachment' is common parlance	Empathy not difficult for those in the attachment-know – outside is more difficult Mental health field get non-verbal communication! Don't agree – interviews don't bear this out Idea that attachment is a catch-all Attachment = bonding confusion Training and education importance
12. I think, the more you can help people see the importance of what happens early on, in a child's brain development and … and .. the consequences of that, for later life; if more	Importance of early intervention recognised Importance of child brain development recognised Important that if profs don't	Education, to open people's minds, re: what happens early on in child's brain development Consequences of not attending to child's brain

emphasis is thrown on that, that that, you know, has a big effect on people's understanding really; but talking about a brand new infant, starting out, that they are open to developing in so many different ways, that if there isn't the right environment for that brain to develop in a healthy way, you know; and looking at all those studies of those Romanian infants and how a low-stimulus environment and neglect, the effect that had on those children's brains; I think that's quite powerful in getting people to see how important it is, you know, that early intervention.	get in early, it results in bigger difficulties later More emphasis on a brand new baby and what they need as they start out Why still quoting Romanian orphans?! There's later evidence but this has stuck in people's minds big time! Powerful images	development Significance of the infant's beginning to life! Impact of children in distress in people's minds! Powerful!
13. Um, I think it's about getting people together, locally, to look at what resources are out there; you know, there are people interested in it [infant mental health], there's perinatal, there's HVs, there's CAMHS and people in CAMHS with a particular interest in it; there's people in adult mental health who do have these concerns and want to be able to offer something; there's the safeguarding agenda, safeguarding within the Trust; and then there's, very much, social care, as well, who are faced with these cases and want to be there for somebody; and voluntary agencies, as well, you know, it's not called DORPIP now,	Need to know what resources are available before generating new ones! Good point! CAMHS Perinatal HVs Adult CMHT Safeguarding agenda Social care There'll be GP, paediatricians, family centres, schools, voluntary organisations, etc Conversations needed!!! Need to be more joined-up than currently people are	Conversations/dialogue Joining together Many people are concerned/interested in under-5s mental health CAMHS HVs Perinatal CMHT Soc care Etc Working together crucial/vital

but whatever it is; So I think it's about getting everyone together to look at what resources you've got and then look at how you can work together, and also bid for more resources. [better/differently resourced, or more?] I think it, probably, does need a bit more; there's a lot you can do already but, as I say, I think, resources tend to get consumed by really urgent cases; I think to make a different you've got to put some money into that [infant mental health] essentially; you can't take it away from the urgent cases but, to make a difference, you've got to put some investment in.	Better/different thinking, what IS first before what NEXT – part of developing a service IS about what is available first – how do you know what's needed if you don't know what's available Investment!!!!!!!	Rethink required rather than drastic changes – this could be/is crucial when thinking about funding, workforce and resources to meet needs/demands Still need an 'emergency'/risk-focused service – Investment still needed
[anything else?] Not really, as I say, I think, within our Trust they are beginning to see the importance and the need, and certainly I've had discussions with the perinatal team; they'd be very keen to work closer with CAMHS, because they recognise they only go up to 1yo, that'll soon be to the age of 2, but that's only with children they're already working with, over the age of one; but they recognise, after that, there is still a need, and there's other cases, that crop up, that don't need [undecipherable] .. so they're quite keen to work more closely with	Discussions/conversations have started – recognition of the importance of getting a good start for under-5s	Going in the right direction – people/services are keen to join-up

CAMHS in thinking about infant mental health as a whole and the foundation of services really.		

Appendix VI Photo of part of the thematic analysis process