Child Psychotherapy in a Paediatric Out-Patient Setting:
How can a Brief Intervention Service contribute to the assessment of Under-Fives?

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Abstract

This research study aimed to find out the contribution of a brief parent-child psychoanalytic psychotherapy intervention to the paediatric diagnostic assessment of children aged under-five. Previous literature and research regarding brief under-fives interventions focused on the clinical application of the model. No accounts of what referrers thought of the intervention, as a means to aid their understanding or assessment of a child, had been undertaken.

Three referred children and their parents were offered parent-child psychotherapy sessions based on the Tavistock under-fives clinical model. Data was gathered from parents through standardised outcome measures. A clinical formulation report drawing upon clinical process note data of the sessions was shared with the child's parents, GP and referring community paediatric clinician. This enabled a bridge to be formed between the clinical intervention and the referring paediatric clinician. A semi-structured interview then took place with the referring community paediatric clinician.

Findings from the clinical intervention were that parents felt the intervention enabled them to understand their child's emotional and behavioural needs better. Interviews with the paediatric referring community paediatric clinicians found that the intervention was considered valuable in a range of ways. This included confirming a paediatric clinical view of the child, helping to avoid possible mis-diagnosis of a neuro-developmental disorder and providing an intervention for the child where universal and paediatric interventions had already been offered and difficulties continued to be experienced.

Paediatric referrers were able to experience referring to a psychoanalytic child psychotherapy intervention for the first time and consider how this could support them in the future in their diagnostic assessment of young children. The provision of the brief intervention enabled a strengthening in the working relationships between paediatric and CAMHS clinicians.

Declaration

I hereby declare that the contents of this thesis are entirely my own work; other sources of information have been cited throughout. Any work, published or unpublished which I have quoted, or to which I have referred, are referenced in the body of the thesis and cited in full in the bibliography. This project has received ethics clearance from the Health Research Authority, the University of East London and permission to conduct the study has also been given from the NHS Trust in which this study took place.

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Introduction

This was a qualitative study aimed at assessing the contribution that a brief parent-child psychoanalytic psychotherapy intervention could make to the assessment of children aged under-five who had previously been diagnostically assessed by the local community paediatric service.

1.1 Rationale for the study

This research study arose from the development of a local provision of a model of brief psychoanalytic psychotherapy for children aged under five, who had traditionally been assessed by the local paediatric service. Existing paediatric clinical pathways for these children focused upon the assessment of neurodevelopmental conditions, such as Autistic Spectrum Disorder (ASD) and Attention Deficit Hyperactivity Disorder (ADHD). There was also limited targeted therapeutic support, such as occupational and speech and language therapy. However, some children did not meet diagnostic criteria for a neuro-developmental condition yet continued to experience emotional and behavioural difficulties beyond what could be supported via universal services, such as health visiting and school nursing.

By drawing upon the literature regarding under-fives brief interventions, and my own experiences of this area of clinical work, I was aware that often the child’s behaviour was communicating a difficulty, either within the parent-child relationship or sometimes between the parents, possibly in the context of trauma experiences, family discord, parental mental health difficulties or substance/alcohol use. Behaviour difficulties that appeared to have become stuck, or seen as located only in the child, could be thought about through the consideration of unconscious material observed within the clinical sessions. It was proposed that a brief parent-child psychotherapy intervention may have something to offer community paediatric clinicians in supporting an understanding of what these behaviours may be communicating about the emotional needs of these young children.

1.2 What are the current mental health needs of children under-five?

A growing interest in understanding the emotional life and mental health needs of infants and pre-school children has enabled the needs of these young children to be more openly considered. Early pioneering psychoanalysts, such as Freud and Klein, observed, analysed and documented their clinical findings in relation to their work with young children in the 1920s and 1930s. Increasing interest in the field of early childhood has continued. Academics and clinicians working in this area have built upon those early theories of psychic development in children, as well as a growing awareness of the longer-term impact that a lack of understanding of the mental health needs of young children could have.

One hundred years of clinical interest, research and literature is now available to clinicians, parents and policy makers providing compelling evidence about the development of infants and young children's emotional worlds within the families they are raised in, and the importance of the quality of the nurturing relationships they receive (National Scientific Council on the Developing Child: 2004). The language of 'attachment', 'bonding' and 'trauma' are no longer confined to researchers and clinicians but have become commonplace in articles promoting the needs of children and of those charged with caring for these babies and children, be it parents, health and education providers, or the state.

In recent years, this interest culminated in the publication of two key UK government reports. 'No Health without Mental Health' (HM Government: 2011) promoted a 'call to action' and outlined six areas in which the government pledged to work towards improving the mental health of the population. One key area was to provide help and support for mental health for children and young people. Later that year, the Munro report focused upon proposed reforms of the child protection system which asserted the need for early intervention in young children's lives, with a stark message of "now or never" (Munro: 2011: 69). It cited compelling neuroscientific evidence of the physical damage to an infant's developing brain when emotional bonds were not warm, nurturing and consistent. Research data was now available which clearly stated the possible repair that could be achieved in brain development in very young children provided with the correct support (Anderson: 2003). As well as the physical and emotional cost to these young children, publications at that time also emphasised the economic benefits to wider society (Action for Children: 2009; Allen: 2011a: Allen: 2011b, Department of Education: 2013).

A shift in UK government focus upon very young infants' mental health needs and the prevention of poor mental health became more evident (Department of Health: 2009; All Party Parliamentary Group: 2015). The language of "transformation" was adopted rather than risking the stark possibility of "intergenerational transmission of disadvantage, inequality, dysfunction and child maltreatment" (All Party Parliamentary Group: 2015: 4). The importance of this shift in approach was likened to the continuing defence of the realm. Recognition of the importance of a child's first two years of life has continued with increased emphasis placed upon shared responsibility of both parents, and the state, in providing adequate care to such young children (Leach: 2017; House of Commons: 2019). Active intervention in the first 1000 days of a child's life it was acknowledged could "improve children's health, development and life chances and make society fairer and more prosperous" (House of Commons: 2019: 3).

The government's policy planning contained in the *First 1000 days of life* was in part influenced by a movement that initially began in the US and considered the impact of 'Adverse Childhood Experiences', or ACE's. This movement has contributed to a longer-term view of how early childhood trauma, abuses and difficulties can impact upon the longer-term mental health of the individual (Burke et al: 2011). The language of ACE's has had resonance within the UK and the mental health needs of pre-verbal children was the focus of government debate (House of Commons: 2019), which recognised the longer-term impact for young children of experiencing four or more adverse child experiences such as abuse, poverty or family discord. Such children are at a much greater risk of poor health outcomes (Danese et al: 2009; Holman et al: 2016). Through the *First 1000 days of life* report, the government wished to address this via national and local goals aimed at reducing ACE's, improving a child's school readiness, reducing infant mortality and child poverty. This was to be achieved through building on the existing 'Healthy Child Programme' (Department for Health: 2009) with targeted services to those in most need, and a focus on prevention via early intervention. A skilled workforce was to be “cultivated…with an enhanced awareness of child development and adversity” (House of Commons: 2019: 3).

The now expanded Healthy Child Programme, with a wider focus and age range, remains the national evidence-based programme to tackle the improvement of children’s health, led largely by health visiting and school nursing. However, despite a growing interest in this field, there are limited research studies regarding the prevalence of mental health disorders within the pre-school population. A similar level of need to that of older populations would suggest a figure in the region of 10% to 15% of pre-school children having a diagnosable mental health disorder (Egger & Arnold: 2006; Skovgaard et al: 2007). At the time this research study was being planned, NHS data was collected for the first time regarding children aged between two to four years which cautiously stated that 5.5% of this population had a diagnosable mental health disorder (NHS: 2017). The charity ‘Young Minds’ stated that such figures under represented the needs of this child population (Young Minds: 2016). They argued that double the number of children than this data had suggested had a diagnosable mental health disorder. Despite this, spending on public health services for children aged under-five years had fallen by 9% since 2014-15 and was projected by The Health Foundation (2018) to fall by another 15% by 2019-20.

In July 2020, a large-scale study by the Children’s Commissioner (2021) reported that clinically significant mental health conditions amongst children had risen by 50% compared to three years earlier. The reality of service provision however highlighted the on-going gap in unmet need. 52% of Child and Adolescent Mental Health Services (CAMHS) were reported to provide a mental health service to children aged under two according to their referral criteria. However, those services also stated that in reality they did not provide a service to children aged under two (Parent Infant Foundation: 2021). A third of surveyed clinicians felt they didn’t understand infant mental health (Parent Infant Foundation: 2021). In the same year, the Children and Young People’s Mental Health Coalition reported that there were “significant gaps in knowledge and skills relating to working with babies and toddlers” (CYPMHC: 2021: 55). The Parent Infant Foundation (2019) stated that although a range of professionals offered clinical interventions to pre-school children and their families, only psychoanalytic Child

Psychotherapists received early infancy training as part of their core clinical training, highlighting the unique skills that child psychotherapy can offer to this population.

The work of raising the profile of the mental health needs of children aged under-five has continued by those clinicians working in the field. A collaboration between the Anna Freud Centre and the Royal Foundation Centre for Early Childhood produced a report entitled ‘Big Change Starts Small’ (Royal Foundation for the Centre of Early Childhood: 2021) which emphasised the importance of the first five years of life. Support in these crucial early years could support children to manage their own emotions and develop health relationships with themselves and those around them.

1.3 The impact of the COVID-19 pandemic on work with young children

At the time of this research study, the future of NHS mental health services was widely debated. The impact of the global COVID-19 pandemic had brought the need for improved mental health services to the fore of mainstream debate. Research found that children and young people’s mental health had “worsened” due to and during the pandemic (UK Parliament: 2021: 2). Findings included a rise in anxiety, behavioural, emotional and attention difficulties. Children with special educational needs and disabilities experienced disproportionately worse levels of emotional difficulties. The increase in children and young people accessing mental health support services increased by 134% (Royal College of Psychiatry: 2021).

To date, the focus of research regarding the impact of COVID-19 restrictions upon mental health has largely been upon school-aged children. In October 2021, the House of Commons Petitions Committee however reported on the challenges experienced by new parents during the pandemic. The committee acknowledged that recovery funding aimed at children under two had been “unjustifiably neglected” and recommended an acceleration regarding the expansion of peri-natal mental health services. This view was supported by three UK charities supporting young children and their families in a recent report ‘*No one wants to see my baby*’ (Parent Infant Foundation: 2021).

Perinatal mental health services are assisted by the Parent-Infant Foundation in thirty-nine ‘infant relationships teams’ within the UK. However, at the time of this research study there was no specialist support team in the locality in which the study was based. Within the wider NHS Trust in which the study was based covering three counties, one perinatal mental health service had been established, which included the provision of psychoanalytic Child Psychotherapists. At present, this service is commissioned to provide a service up until the child’s second birthday, so a gap in provision continues to exist.

I will now outline how this research study was conceived and developed, drawing upon the Tavistock under-fives clinical model.

1.4 The research study

The idea for this research study evolved from an existing provision of a brief parent-child intervention that I participated in delivering within my clinical training. A brief model of parent-child psychotherapy was offered in the paediatric out-patient service of the local hospital. This intervention had been developed to consider the potential value of the intervention within the wider paediatric diagnostic assessment of pre-school children experiencing emotional and/or behavioural difficulties.

Over the duration of the research study being developed and ethical approval being sought, changes in my clinical base led to the brief parent-child psychotherapy intervention being offered within a locality where an intervention of this nature had not previously been available. Prior to the start of the research project, introductory meetings were held with the paediatric service to outline the aim of the project. Initial meetings were held with paediatric Lead Clinicians, followed by a day observing the mechanism of how pre-school children were assessed within the paediatric neuro-developmental diagnostic assessment nursery. A final meeting was held with the paediatric service to inform them of the routine brief intervention that was being offered to children aged under five, as well as inform them of the intention to research a sample of the referrals.

Due to a limitation in local paediatric clinical space, it was unfortunately not possible to offer the intervention within the local paediatric clinic. Opportunities therefore to strengthen the links between child psychotherapy and paediatric clinicians were significantly reduced due to this practical obstacle. The brief parent-child psychotherapy intervention was subsequently offered within a community mental health service providing specialist mental health assessments and treatment for children and young people aged 0-19 years of age. The service provided a range of mental health treatments, including psychoanalytic psychotherapy, clinical psychology, systemic psychotherapy, and psychiatric treatments. Most children and young people referred to the service were largely of secondary school age.

Within the paediatric service, a multi-disciplinary approach to assessing young children, involving Community Paediatricians, Speech and Language Therapists (SALT) and Occupational Therapists (OT) had been established. Due to this, a wider definition of the referring clinician was adopted in the research study to expand from ‘referring community paediatrician’ to ‘referring community paediatric clinician’ to reflect that most referrals to the intervention were made by SALT and OT trained clinicians.

The study involved an intervention cohort of up to five children referred by their paediatric community clinician. A brief parent-child psychotherapy intervention based on the Tavistock Under-Fives clinical model was offered to the child and parent/s. Standardised outcome measure data completed by the parent was included within the data analysis. Narrative information regarding the referred child and the clinical intervention offered to them was also recorded within clinical process notes. These notes were used to provide a Clinical Formulation report at the end of the intervention to the parent, referring community paediatric clinician and the child’s GP. This provided a rich triangulation of perspective from the referring community paediatric clinician, the parent, and the Child Psychotherapist.

After written consent was gained from the child’s parent to use data regarding their child in the study, the referring community paediatric clinician was asked to consent to be interviewed about how they had experienced the contribution of the brief parent-child intervention. Data was collected through a semi-structured interview format.

1.5 Outline of thesis

In this thesis I will begin with a review of the literature and provide an overview of early childhood in psychoanalytic and child development literature, including the contribution of early pioneer’s clinical work with young children. I will outline the literature regarding brief clinical work with under-fives in relation to clinical applications and to outcome research. I will also consider the small amount of research that has considered the views of referrers within clinical work. I will conclude with an outline of online therapeutic clinical work to reflect the changes that were needed within this research study due to the global COVID-19 pandemic.

In the Research Design & Methodology chapter, I will describe the methodology used within the study and the rationale for this. This will include a description of the intervention cohort, including the inclusion and exclusion criteria, followed by a description of the sample, as well as consent, recruitment and ethical considerations. I will describe how the data was collected in the format of standardised outcome measures collected from the intervention cohort of parents and the semi-structured interviews with the referring community paediatric clinicians. An outline of Interpretative Phenomenological Analysis (IPA) will then be presented through a detailed section of the stages of analysing the collected data.

Following this, I will present a clinical narrative chapter to provide detail regarding the intervention cohort of children, their main presenting difficulties and the brief parent-child intervention that was offered to them.

I will then detail the findings of the research study based upon both quantitative data from standardised routine outcome measures and qualitative data in the form of anonymised verbatim data from the semi-structured interviews with the referring community paediatric clinicians.

A concluding chapter will place this research study within the wider context of research and clinical work with children under-five and studies that have sought to elicit the views of referring clinicians to mental health services for children and young people. The possible contribution that this study has made to the field of interest in this area will be evaluated. Recommendations for further research and application to clinical practice will be considered. The thesis will conclude with my personal reflections on conducting the study and its strengths and limitations.

2 Literature Review

This chapter aims to outline the field of interest of which this study forms a part. To undertake a literature review I searched book and journal databases using the following databases – PsychInfo; Research Gate; EbscoHost; PEP Archive and the Tavistock and Portman library. The searches enabled me to identify both familiar and new texts within the field of child psychotherapy and more widely. To search for relevant texts, I used a number of phrases to reflect the area of the research study I aimed to review. Search terms included brief child psychotherapy; under-fives; parent-infant psychotherapy; parent-child psychotherapy; referrer; paediatric assessment and paediatric CAMHS liaison.

As some areas of the search undertaken identified a wide number of texts, I aimed to focus on those texts most salient to my research study. I considered those clinical papers and research studies which focused on brief psychoanalytic psychotherapy with children aged under-five and its application in clinical work. During my search, I became aware that there was no clear definition of 'brief' clinical work with under-fives. A range of studies employed clinical models offering five sessions, similar to the model used within this research study. However, I was aware that other studies offered more sessions, yet were still considered to be brief. There was also some overlap in the literature between parent-infant psychotherapy and parent-child psychotherapy. Some texts appeared to consider parent-infant psychotherapy pertaining to the first year or two of childhood. Based on my previous experience of offering the clinical intervention where the children were aged three or older, I used the term 'parent-child' when describing the intervention being offered as part of the study.

The chapter sets out to provide an overview of early childhood within psychoanalytic and child development literature and will consider the contribution of founding psychoanalysts, key theoretical papers and the contemporary continuation of these early works.

The chapter will then consider the development of psychotherapeutic work with young children, influenced by the importance of infant observation within the clinical training of Child Psychotherapists and its application in clinical work. The development of the Tavistock Service Under-Fives Service and the Anna Freud Centre's Parent-Infant Psychotherapy (PIP) will be considered and their links to the use of psychoanalytic theory and infant observation as a clinical technique.

Having outlined the history and clinical context of the development of this specialism, the chapter will move on to focus upon the literature and research regarding psychoanalytic brief work with children under five. Clinical application, considered by way of symptomology and clinical setting within the literature, will be outlined prior to summarising the small body of the evaluation studies regarding this clinical approach.

As the aim of this research study was to consider the experience that referring paediatric clinicians had regarding the provision of a brief parent-child psychotherapy intervention, there will be a short discussion regarding previous literature and research with a similar focus.

The chapter will conclude with an examination of the literature regarding 'technology assisted' clinical interventions (ACP: 2020) which became an important, yet unforeseen part of the delivery of both the clinical intervention and research interviews that formed this research study.

2.1 Pioneers of clinical work with young children

An interest in early childhood stemmed from an acknowledgement of the impact of early life in psychoanalytic work with adults. This resulted in a greater curiosity about the emotional development of young children. The power of their unconscious processes were thought to be observed and expressed through verbal and non-verbal communication. Early observations of childhood development occurred and led to the furthering of psychoanalytic theories.

Freud is widely acknowledged as an early pioneer of working with young children. His clinical interest in instinctual impulses, alongside the temperance and tolerance of reality through emotional development, included a focus upon early psychic development. His analysis of a boy named Hans (Freud: 1909a) between the ages of three and five, was the first clinically documented analysis of a child. The study provided Freud with direct clinical observations which would support his wider theories of infantile sexuality and the Oedipus Complex.

In a later work, ‘Beyond the Pleasure Principle’ (Freud: 1920), Freud returned to considering his observations of children playing. He surmised that the repetitive nature of their play was a repeating and working through of an experience that had left an impression upon them to enable them to achieve greater control of the experience. This repetitive play was observed by Freud in the throwing and retrieving of a cotton reel by an 18-month old, a re-enactment of “disappearance and return” (Freud: 1920: 15). Freud interpreted this play as the child transforming the experience of the loss of an object. By being subsequently re-united with the object when the cotton reel was pulled back towards him, the child symbolically mastered his anxiety in relation to his mother’s own disappearance and return as he experienced it.

Based upon his observations, Freud said that play was dominated by a “wish to be grown-up” (Freud: 1920: 17) and even unpleasant, frightening experiences could be re-enacted upon a playmate as a means of passing on the “disagreeable experience”. In 1933, Freud further proposed that the development of the infant’s super-ego was “constructed on the model, not of its parents, but on its parents’ super-ego” which was an internal representation of the parents’ parents” (Freud; 1933a: 98). The power of generational unconscious influences continues to resonate with clinicians working with young children and parents today (Fraiberg: 1975).

The psychoanalytic theories formulated by Sigmund Freud were applied by Melanie Klein and Anna Freud in their work with children. Klein’s child analysis introduced a box of toys into the consulting room and enabled pre-verbal children to be analysed through their play. The analyst was also placed in roles which would enable the interpretation of the child’s internalised adult figures. Klein’s interest in the analysis of early childhood continued to explore the instinctual aspects of personality development, introduced by Sigmund Freud, and its relation to their external objects. She wrote on extreme states in early childhood which she defined as ‘paranoid schizoid’ and ‘depressive position’ states of mind (Klein: 1935). In the paranoid schizoid phase of development, the infant experienced the world as a confusion of contradictions and dangers and was unable to integrate the aspects of his needs being met by his maternal object, alongside aspects of the same maternal object that withheld or made him wait for his wants and desires to be met. Klein described an integration of these aspects at around 6 months in typical development, during which the infant brought together in his mind an idea of a mother who both satisfies and frustrates. This phase she defined as the depressive position.

Anna Freud began working with children in Vienna in 1924 and published the *Introduction to the Technique of Child Analysis* in 1927. She promoted the analysis of children's dreams, play and drawings and noted a link between a child's symptoms and their developmental stages. She promoted working with a focus upon the child's environment for pre-latency children. She proposed the development of a positive alliance between the therapist and the child enabled her to gain their attention and trust. Freud also recognised each child as an individual which was an important early development in considering the voice and needs of the child.

Following the First World War an interest in dysfunction within children and its relation to their parents and family context grew. Clinics were founded which provided opportunities for clinicians to write and publish papers detailing their work in this area to a wider audience. In 1928 Margaret Lowenfeld, a paediatrician, opened one of the first Child Guidance Clinics called the 'Children's Clinic for Treatment Study of Nervous and Difficult Children' in London. Lowenfeld went on to pioneer the sand tray technique which she published in 1935 and continues to be an important text in Play Therapy. In 1951, Anna Freud founded the Hampstead Clinic which aimed to treat children with emotional disturbance irrelevant of their social circumstance. It was here that simultaneous mother-and-child therapy was practiced under the supervision of Dorothy Burlingham, a joint founder of the clinic.

At this time, John Bowlby, a psychiatrist, was also working in the London Child Guidance Clinic and began to question long held beliefs about parent's relationships with their children being distant to avoid raising a "needy" child (Levy & Orleans: 1998: 13). Bowlby (1951) was credited with proposing Attachment Theory which continues to be a central theory in work with children and parents. Mary Ainsworth further developed Bowlby's key ideas and proposed the concept of a 'secure base' (Ainsworth: 1967). Mary Main further developed Bowlby's attachment theory via her longitudinal studies from which she classified 'disorganised attachment' as a fourth category of attachment. Main observed parents who had often experienced abuse or neglect and the anxieties related to this as being communicated by the parent towards their own child. This was said to contribute to a controlling yet rejecting response within the child (Main & Cassidy: 1988).

The link between paediatrics and psychoanalysis continued with the work of Winnicott who approached the subject from his dual training as a paediatrician and psychoanalyst. He introduced an in-depth appreciation of the role of observing the mother-infant dyad. This led to what we now widely accept as 'Parent-Infant Psychotherapy'. Winnicott emphasised the importance not only of the instinctual needs of the infant, and their growing acceptance of the reality of their external objects, but also considered the state of mind of the infant's mother. This he defined as the "primary maternal pre-occupation" (Winnicott: 1956) and the interplay, or 'reverie' between mother and infant. He promoted a goal of 'good enough mothering' which continues to have resonance within clinical work today.

Bion's theory of 'container and contained' furthered this understanding. The power of the emotional communication of the infant and the parent's ability to withstand and "contain" the emotional projections of the infant is key to Bion's work (Bion: 1963). He described the infant being in the grip of psychotic or persecutory anxiety and transmitting what he referred to as "beta elements". He stated that if the mother was open and responsive to the child's states of mind to provide an emotional, and not just practical response to these feelings and needs, whilst not becoming overwhelmed by the anxiety of this role, these beta elements could be detoxified and made bearable. Like Winnicott, Bion acknowledged the importance of a supportive environment, partner and family for the mother to be in an emotionally receptive state of mind herself.

Since the 1970s a growing interest in the field of infant mental health contributed to the development of a body of research and literature by disciplines such as developmental psychology and psychiatry alongside psychoanalytic and child psychotherapy approaches. This included texts considering the emotional life of infants and young children contained in the Tavistock Clinic Series (Cohen: 2003; Emanuel: 2008; Adamo & Rustin: 2013 and Wakelyn: 2019) and the *Understanding Your Child* books (Miller: 1992; Boswell: 2004; Gustavus-Jones: 2004; Miller: 2004; Emanuel: 2004). A rich body of child development literature has contributed to our understanding of the emotional difficulties of children, including papers specialising in autism, play and symbolism and language development (Trevarthen: 1993). A specialist area has branched off within psychiatry focusing on perinatal and antenatal mental health and their impact on parenting (Murray and Cooper: 1997; Diego: 2004). Contemporary papers have documented developments in neuroscience (Field et al 2002; 2002a; Fonagy & Target: 2003 Green: 2003; Music: 2016; Sutton: 2019).

I will now consider how this knowledge has been applied in the development of psychoanalytic focused work with young children.

2.2 Psychoanalytic work with young children

Over one hundred early intervention programmes aimed at supporting young children emotional well-being are currently in existence (Early Intervention Guidebook: 2022). Within the field of psychoanalytic work with children aged under-five in the UK, two clinical models have built upon the work and research of early psychoanalysts. First is the Tavistock under-fives clinical model. Second is the Parent-Infant Psychotherapy model. I will now briefly outline the two clinical models.

The Tavistock under-fives intervention provided the clinical model on which the present study was based. The specialist service set up in the early 1980s was created in response to a growing need for early intervention as a preventative form of treatment. The clinical model drew heavily upon Child Psychotherapists use of observation as a therapeutic technique, alongside an in-depth knowledge of child development (Miller: 1992b, Barrows: 1999a, Emanuel: 2008). Infant observation developed from the work of child analyst Esther Bick, who introduced, taught and supervised infant observation within the training of Child Psychotherapists in 1948. From birth to the child's second birthday, weekly observations of an infant and their mother within the home environment would take place. The aim for the observer was to be "...in the active position of being emotionally receptive and tuned in to the actions, the atmosphere, and the feelings of the people observed" (Pozzi: 2003: 7). To support this task, weekly small group seminars with others undertaking infant observations were held during which the fine detail of the observation of the infant, the unconscious processes that may underlie their communication and the emotional responses of the observer were considered.

Miller (1992b) suggested that brief under-fives work required the use of "observation at all levels, to promote states of mind conducive to thinking". Being able to consider and bear the positive and negative feelings in relation to the clinic and the clinician, through attendance to transference and countertransference experiences were also considered important aspects of the clinical model. Infantile phantasy and anxieties can be evident, not only within the referred child but also the parental couple, at times of high emotional distress.

Martha Harris (1966) utilised infant observation as a key skill within her work offering 'therapeutic consultations' which was an early form of the under-five's intervention. Wider recognition of the importance of the technique within psychoanalysis has also been made and over time infant observation has attracted worldwide interest and application. Contemporary applications of the technique have been evidenced in papers such as Houzel (1999); Delian (2000) and Rhode (2007) and in initiatives such as 'Watch, Wait and Wonder' (Muir: 1992) and 'Watch Me Play!' (Wakelyn & Katz: 2020).

Observations of the child and their parent/s in the clinical room that enabled the Child Psychotherapist to gain an understanding of the emotional functioning, use of play and behaviour of the referred child were central to the Tavistock under-fives clinical model. These observations were openly thought about by the Child Psychotherapist and parent/s as a vehicle for understanding what such interactions might be communicating and its' relation to the presenting difficulties. Through this process, anxieties could be identified and relieved, in order to unblock developmental potential in children and parents and to facilitate a means of growth in the child and parent taking place. Essentially, the psychotherapist aimed to facilitate understanding in terms of the relationship between the child and family. It was not solely reliant on what the child brought, as the child does not develop in isolation from their family. The task of the child psychotherapist was to facilitate parental insight into their own complex, and often unconscious communication, and its relation to the parenting of their child. In this way, the parents state of mind was as important to observe and communicate to, as that of the referred child. As such, clinical sessions were often offered to the child's parents alone to consider generational aspects of trauma, mental health, alcohol/substance use, family discord and domestic abuse. Part of the role of the Child Psychotherapist was to challenge parental held beliefs, and to manage the complexity of defended parents. There are complexities in working within unconscious projections of the parents and the child, in a context in which parents may arrive feeling despondent or judged in relation to their parenting. Working with another Child Psychotherapist in the room can be beneficial to sufficiently contain the family, whilst creating a thinking space.

Due to the briefness of the work, the aim was not to alter the nature of representations evoked by the parent-child relationship but rather to realign these representations away from the child and back to the unresolved conflicts within the parent's own relationships (Hopkins: 1992; Stern: 1995). In this way, the child can be relieved of powerful projections from the parent to the child. The focus of the brief intervention was understanding the transference between the parent and the child, rather than the primary interest being the transference relationship between the parent and the Child Psychotherapist, though this was held in mind during the intervention. The parent-child transference relationship was considered by trying to understand the parents' own experiences as a child and how they may now be impacting upon their relationship with their child in the present. The young age of the child and the parents' wish to not repeat difficulties they experienced within their childhood, were considered motivators for change to be more quickly achieved.

The second model developed was Parent-Infant Psychotherapy (PIP) led in the UK by clinicians working at the Anna Freud Centre, who also provide training in this clinical approach, drawing upon the work of Fraiberg (1975) and Bick (1964; 1968; 1986). This model of therapy offered to infants up to the age of eighteen months aimed "…to involve the baby as an active and creative partner in the therapy" (Raphael Leff: 2016: ix) and to harness the infant's brain plasticity, alongside the parents' potential for change based on a "…reactivation of their unresolved infantile issues" (Raphael Leff: 2016: x) The approach drew upon psychoanalytic object relations theory, and the work of Winnicott in observing the parent-infant dyad, alongside contemporary neuroscience. Over the duration of one year, the psychotherapist, aided by a video recording of clinical sessions, aims to be "exquisitely sensitive to her own embodied cues" to the baby and parent. The use of a recording facilitated parent feedback, reflection and discussion, as well as further research, audit and training.

This clinical model was the focus of a randomised controlled trial (RCT) undertaken by Lieberman et al (2005). Seventy-five mother-infant dyads who had been exposed to domestic abuse within the parental relationship were randomly offered either one year of Child-Parent Psychotherapy (CPP) compared to case management and referral for individual treatment. The study demonstrated the efficacy of CPP on the child's behaviour, trauma stress symptoms, diagnostic status and the mother's Post Traumatic Stress Disorder (PTSD) symptoms. A follow up study completed six months later (Lieberman et al: 2006) evidenced durability of CPP in reducing the child's behaviour difficulties and the mother's overall distress. These studies were significant in introducing an evidence base to support the use of CPP as a relationship focused therapeutic intervention in response to trauma experiences.

I will now move on to consider the body of literature regarding brief child psychotherapy with under-fives.

2.3 Literature regarding brief parent-child psychotherapy

Clinical papers detailing brief psychotherapy with under-fives children tend to fall into four categories. First, a growing body of literature focused upon the child patient's symptomology and the response of child psychotherapy to gain understanding and attempt to alleviate the distress that such symptoms may have upon the child and their family has developed. Second, there were several clinical accounts of applied parent-child psychotherapy within settings outside of the usual CAMHS clinics or consulting rooms. Third, a body of work focused upon the clinical work with parents within this type of intervention had been established. Finally, a smaller but developing area of literature evaluating the potential outcomes of this type of clinical approach had developed. Such an approach is welcomed within the current growing climate of evidence-based practice. I will now summarise each of these distinct areas in turn.

First, Child Psychotherapists working with young children and their families have provided a breadth of clinical interventions aimed at alleviating a range of symptomology. Common disturbances such as sleep difficulties, related anxiety around separating (Daws: 1989; Likierman: 2008; Pozzi: 2003), feeding and weaning problems (Daws: 1999; 1997; Thomson-Salo: 2018); toileting (Barrows: 1996) persistent crying, (Acquarone: 1992; Hopkins 1994) and challenging and aggressive behaviours feature in the clinical papers in this area (Miller: 2008; Urwin: 2008). In particular, a focus upon the quality of the parent-child relationship, such as that of attunement (Beebe & Sloate: 1982), oedipal processes (Daws: 1999b; Gurion: 2008) or attachment difficulties (Leiberman & Zeanah: 1999) were also evident.

Complexity in presentation either due to neurodevelopmental, learning difficulties and/or issues regarding safeguarding have also been presented, including a focus upon those infants who may be considered ‘at risk’ of a diagnosis of ASD (Delian: 2000; Acquarone: 2016; Rhode: 2016). The value of therapeutic interventions focused on strengthening the relational aspects of development involving infants and their parents has been considered (Green at al: 2013 and Singletary: 2015). Green et al (2013) reported on modifications in the development of a small group of seven infants aged between 8 to 10 months of age. This sample of children had an older sibling diagnosed with ASD. Twelve 1.5-hour videoed sessions within the child’s home were offered focusing upon parent-infant dyadic interaction. Parents reported “an enriched sense of their infant’s individuality” and increased enjoyment in their interactions (Green: 2013: 10). In Singletary’s study (2015) the benefits of a psychoanalytic intervention for young people with ASD through “uncovering the child’s inner world of feelings and meanings” were reported (2015: 81). Rhode (2016) presented clinical work based on observation with young infants who had been assessed using the Checklist for Autism in Toddlers (CHAT) developed by Baron-Cohen et. al (1992). Children were categorised into high, medium and low risk categories of being diagnosed with Autism after the CHAT was completed. Rhode demonstrated how the therapist working with these at risk children provided descriptions and possible meanings, of the child’s behaviour based on her observations of the child in the presence of their parents. Encouragement of the parents own capacity to observe the child in this way forms part of the work. Through the at times painful presentation of the clinical case, ‘Isabel’, Rhode described the “vicious circle of discouragement” (Rhode: 2016: 263) as she supported Isabel’s parents to move from their position of scepticism and own despondency to begin to acknowledge the connection that Isabel was forming to them.

Second, clinical application of child psychotherapy in community settings, other than mental health clinics, is not an innovation. Following the impact of the work of James and Joyce Robertson captured in their films of young children’s experiences of separation in hospital in the 1950s and 60s, child psychotherapy continued to document how such settings and institutions may think about their work with children, parents and staff. Grauso Malliani (1984) wrote of her experience of working with a psychoanalytic focus in a paediatric hospital ward. She noted the anxieties held by the paediatric staff during their duties. Child Psychotherapists have also written about their experience of working with children and their families within hospital settings, such as neo-natal units (Fletcher: 1983).

Vas Dias (1990) wrote about collaborative opportunities during clinical work in a paediatric outpatient clinic where pediatrician’s referred children for a range of physical issues, such as soiling. The role of the Child Psychotherapist was considered an “integral” part of the joint clinic that was established. From this experience, Vas Dias observed that “just as doctors and nurses gain and develop new insights and techniques through working with the “psych” worker, so do new techniques develop for the “psych” worker in paediatrics” (Vas Dias: 1990: 7).

Other writers have detailed some of the areas of difficulty, and the benefits, in providing psychoanalytic work in such settings. Schmidt Neven (1995) presented her experience of setting up a psychotherapy clinic within a paediatric hospital in Australia. The provision of clinical work was different from the under-fives model used in this study, as one psychotherapist met with the child and another with their parents. Referrals were also accepted for older children and adolescents too with the focus on prevention through flexible support where difficulties were in the early stages. Schmidt Neven drew upon the Tavistock under-fives service and Young People's Consultation Service clinical models and aimed to provide up to six sessions. Of interest to my study was Schmidt Neven's observations of the value of paediatric skills to the psychotherapy intervention being provided. Schmidt Neven observed the overlap in physical and emotional difficulties and concluded that working with a

> *…paediatric colleague who could bring expertise and experience from her own work setting, points to the tremendous potential and expansion of ways in which psychodynamic understanding can be applied and how colleagues such as pediatrician's can bring skills that can act as an important container in a practical sense for the therapeutic work to take place.* (Schmidt Neven: 1995: 116)

Working collaboratively across disciplines may bring difficulties. Kerbekian (1995) wrote of her observations of structural barriers in health organisations that can prevent such joined up approaches, and cause confusion for parents and carers. Kerbekian was working in a neo-natal unit for premature babies and commented on the separation between staff in obstetrics and paediatrics. This resulted in a mother being admitted to one ward and her premature baby being treated in a separate neo-natal unit, reducing the likelihood of early bonding taking place.

Ryz & Wilson (1999) detailed clinical work within a paediatric out-patient department, as this research study was originally intended to be. They applied the Tavistock under-fives service model to work in this setting. The nature of the clinical work and endings however were the focus of the paper. There was no inclusion of what the referring clinician, in this case a dietician, thought of the intervention provided. The paper however, raised a salient point regarding knowing when to end an intervention

> *It emphasizes the importance of containment without undue infantilization and undermining of parents' adult capacities. As professionals it seems important for us to keep in mind the notion of a 'good enough' intervention and thus avoid the dangers of acting out an omni-potent phantasy where only our involvement is seen as helpful.* (Ryz and Wilson: 1999: 400)

Child psychotherapy with children aged under-five has also been applied within a range of community settings. Folkart (1964) and Bandler (1987) gave separate accounts of working in a child psychotherapy role within an adult in-patient setting. Folkart's paper addressed some of the possible difficulties in accepting referrals directly from the inpatient mother and the need to think carefully about the motivation and timing of the referral. Bandler (1987) focused upon the need to work with a range of other clinicians when providing child psychotherapy in an adult in-patient setting. She reflected on how this task may not be an easy one, even when clinicians were located in the same building or service and centred upon the impact that working with parents in such a setting can cause, leading to clinicians feeling over-whelmed, strained and burdened.

Daws (1999) wrote about her experiences of providing a psychoanalytic service within a GP clinic. She found one of the benefits of basing the work within the surgery was to assist GP staff to understand "the emotional meanings of some patients' symptoms, and the feelings aroused in themselves by patients" (Daws: 1999: 9). In particular, Daws focused her consultation work with Health Visitors in the surgery and detailed the range of emotional responses they had to some families – irritation, anger and feelings of uselessness. The value of the work was partly supporting these clinicians to "keeping going" (Daws: 1999:16).

Tydeman & Sternberg (2008) also detailed their experience of working within a GP setting accepting referrals from GPs, Health Visitors and nurses. As in this research study, feedback was provided to the referrers; in this study this was given verbally within a team meeting. Tydeman and Sternberg (2008:112) proposed that this

> *…enables other members of other disciplines to understand and engage in the thinking process. The team hear about the attention to detail and willingness to grapple with negative perceptions and experiences. The reflective process that takes place in the team helps each member to recognize his or her own emotional responses to the patients.*

They agreed that a psychotherapeutic presence in the clinic could support staff to “access their own thoughtfulness and sensitivity” (Tydeman & Sternberg: 2008: 112).

Child psychotherapy in school settings has been documented by a number of Child Psychotherapists. Jenkins (2021) provided a helpful summary of the development of child psychotherapy in primary schools. The importance of providing a space for teachers to think and talk about the impact of the work was stressed as “crucial” (Jenkins: 2021: 57). In terms of pre-school aged children, Zaphirou Woods (2000) provided an account of working in a consultative way with parents and children within a nursery toddler group at the Anna Freud Centre. Leaders in the nursery came from multi-disciplinary backgrounds and included teachers, social workers and Child Psychotherapists. The leaders worked in consultation with a Child Psychotherapist. Weekly discussions between these disciplines were key to planning an intervention with a child and parent.

Fenton & Suschitzky (2021) presented their experience of providing a psychoanalytic psychotherapy five session consultation model to families and staff in an inner London nursery school. Their experience highlighted the importance of working in collaboration with school safeguarding leads, and when necessary, safeguarding services. Again, the importance of providing a reflective thinking space for teachers and staff to consider the emotional aspects of their teaching work was emphasized.

The motivation for the development of such examples of clinical work have often arisen in contexts of professional links made by an individual or small group of clinicians. This may be in relation to a clinical interest in a particular presentation or acknowledgement of the benefit of working clinically across a number of disciplines or funding structures. Collaboration has continued to be a key aim of clinical work undertaken within NHS settings. Liaison services have been established between paediatrics and CAMHS to provide a bridge between acute paediatrics, psychiatry and psycho-social aspects of care. Ramsden (1999) presented the range of interventions offered by Child Psychotherapists working in hospital settings. She saw the work of child psychotherapy being ‘applied’ that could range from one-off consultations to parent work and longer-term work with a child. Of great importance was the relationship of the Child Psychotherapist with the wider hospital team

> *Most Child Psychotherapists working in this hospital context underline the singular importance of their relationship with colleagues in the hospital. This support is practical and reciprocal and operates at all levels of the system from consultant to student nurse* (Ramsden: 1999: 142)

Sutton (2002) also emphasised the link between physical and mental health conditions which he stated required links between paediatric and therapeutic approaches. Through the presentation of case material regarding ‘Jenny’, challenges were considered which included how to stay within the boundary of the role when working in partnership with medical professionals. Sutton also questioned what paediatric colleagues could learn from a child psychotherapy approach and vice versa.

Briggs & Racine (2007) described an example of paediatric and mental health clinicians working together through the co-location of a clinical psychologist specialising in under-fives mental health within a paediatric out-patient setting. The success of the program was limited in its replication they argued due to funding problems and a lack of suitably trained mental health clinicians.

Where a paediatric liaison service was available, it has often been seen as valuable. Woodgate and Garalla (2006) concluded that there was a desire from clinicians to see such services expanded. Support was provided in cases where the presenting child's illness had a psychological component, or where psychological distress was caused because of an illness. However, paediatric liaison services outside of larger cities can be limited and of course may not always include a psychoanalytic perspective.

The body of literature focused upon detailing the range of applied psychoanalytic work with children in a variety of hospital, community and school-based settings helped my reflection on the long tradition of this way of engaging, not only with children and families, but with a range of professionals. The studies and papers summarised here have highlighted the challenges and opportunities that can exist in such services and the value that can be gained through innovation in providing psychotherapeutic support to children.

Third, several papers have also focused upon the clinical learning gained from working with parents during parent-child interventions. The vital importance of change in parents was emphasised in these accounts. Bower (1995: 83) concluded that for a shift to be made in parent-child psychotherapy "an emotional shift in the parent is essential". Daws (1997:188) stated that as clinicians "we need to listen to the parents' cries before they can hear their babies' cries". Schmidt-Neven (2005) highlighted the importance of the shift in working with parents in brief work, alongside the changes in the referred child's difficulties. The role of the therapist was emphasised as one which will work with the parent to enable them to reach their "own insight, which will in turn promote their relationship with their child" (Schmidt-Neven: 2005: 191). The couple 'state of mind' and the need to be mindful of parental mental illness during clinical work with young children and their parents has also been the focus of clinical papers (Murray: 1988; Morgan: 2001).

The role of fathers within brief parent-child psychotherapy was also documented (Barrows: 1999b; 2004; 2008b Emanuel: 2002; 2008; Baradon: 2019). The importance of the triadic relationship cannot be underestimated. When there is an absence of a paternal figure, it is important for this to be considered within the clinical intervention. An intervention provided by two Child Psychotherapists can enable the modelling of a joint parental functioning to be alive and thought about within the consulting room.

Lastly, the term ‘evidenced based practice’ has become more widely used within NHS services. In a climate of limited resources and funding, National Institute for Health and Care Excellence (NICE) guidelines have been developed. These guidelines steer the recommended use of medical and therapeutic resources to enable both clinicians and parents to make informed decisions regarding the provision of interventions for certain presenting illnesses and disorders. Child Psychotherapists have actively engaged with the consultation and development of such guidelines, to ensure that where psychoanalytic perspectives can be evidenced, they are considered alongside comparable clinical alternatives such a cognitive behavioural approaches.

The development of research focused upon outcomes that could be more generalisable within the field of brief parent-child psychotherapy interventions is still in its’ infancy. Cramer and a team of researchers (1990) presented an outcome evaluation regarding thirty-eight families participating in either brief psychodynamic or interactive guidance mother-infant psychotherapy. Their model consisted of up to ten clinical sessions with evaluations of the treatment at the start, as well as at six and twelve-month intervals. The study concluded that “major changes” in the child’s presenting difficulty and relationship between parent and child were evident.

Three further studies have evaluated the outcomes of brief parent-infant psychotherapy to paediatric treatment as usual – Robert-Tissot et al (1996); Cohen et al (1999) and a follow-up study (Cohen et al: 2002), and Georg et al (2020). Robert-Tissot et al evaluated seventy-five mother-infant cases offered psychodynamic therapy and interaction guidance therapy with infants aged under thirty months. A maximum of ten clinical sessions were offered. No discernible difference was noted between the two types of intervention. This research also concluded there were positive outcomes in the child’s emotional presentation and the mother’s self-esteem with positive benefits apparent at a six month follow up.

Cohen and a group of researchers (1999) compared the effectiveness of the ‘Watch, Wait and Wonder’ (WWW) intervention with psychoanalytic mother-infant psychotherapy for a sample of sixty-seven cases of children aged between ten to thirty months where weekly sessions were provided over a five-month period. WWW was found to elicit a greater shift towards an organised and secure attachment base. However, a follow-up study in 2002 evaluated outcomes for fifty-eight of the cases and found progress from both types of intervention but at a different pace, with some advantages in treatment seen in the WWW cohort in relation to mother’s responding to behaviours and parental stress levels.

Georg et al (2020) undertook a randomised control trial with a large sample of 154 mothers and infants aged between four and fifteen months. The study was based on a manualised, four session clinical model of psychodynamic ‘focused parent-infant psychotherapy’, referred to as fPIP. Sixty-nine cases were offered fPIP compared up to five sessions with a paediatrician. Findings included overall improvement in infant emotional regulation, measured through a questionnaire focused upon crying, sleeping and feeding. The mother’s psychological distress was also reduced. There was also a lower drop-out rate and higher participant satisfaction recorded in the fPIP sample. Other research studies have focused upon positive shifts in parental states of mind during the delivery of brief psychotherapy with under-fives include Lee et al: 2012; Early Intervention Foundation: 2015; Anagnostaki et al: 2019.

Douglas & Brennan (2004) presented their findings of a small sample of thirteen children referred by Health Visitors who had been offered up to five clinical sessions using the Solihull Approach. This approach was based on the Tavistock under-fives clinical model. This study included some feedback from the referring health visitor. Health Visitors were asked to rate the child’s difficulties and the parent’s anxieties in relation to difficulties at three stages. The study also noted feedback from the referring Health Visitors who felt more able to identify possible attachment difficulties and respond to them within their role. This study has some aspects of methodology which were similar to this research study. The study found a reduction in the child’s presenting difficulty and the corresponding parental anxiety level.

More recently, Salomonsson and fellow researchers (2020) presented their research findings from a sample of one hundred cases offered a short-term psychodynamic infant-parent intervention based on a four-session average model in Sweden. The intervention aimed to evaluate the impact upon parental depression and the social-emotional functioning of the infant. The findings evidenced a significant decrease in both measures over time.

In summary, I found that there was a large body of literature regarding psychotherapy with young children. I was encouraged to read the number of completed studies with large samples of parents and children recruited which had evidenced positive outcomes in the clinical work undertaken. The brevity of the work in some of the studies also continued to highlight the flexible ways in which psychoanalytic work was applied. However, there were few studies that aimed to utilise the five-session model alongside consideration of the contribution of the intervention for the referrer. I will now consider research that has aimed to research this aspect of clinical work with children and young people.

2.4 Literature considering the referrer's perspective

Specific to this research study was a focus on considering how the referring community paediatric clinician experienced the contribution of the intervention for the child they referred. I discovered that this type of focus in research literature was very limited.

A systemic review of research literature focusing upon possible barriers to primary care clinicians - largely GPs - referring children and young people to mental health services was undertaken by O'Brien et al (2016) who reviewed forty-three studies undertaken between 1984 to 2014, nine of which had been conducted in the UK. The majority of the other studies had been conducted in the US. These included both quantitative and qualitative studies ranging in participation size from seven (Hinrichs: 2012) to 348 participants (Bryce & Gordon: 2000). Research that considered referral to a specific intervention were not included.

O’Brien (2016) found that primary care clinicians experienced difficulties in accessing specialist mental health services due to a lack of specialist mental health providers, particularly in rural areas, and long waiting times. They expressed a lack of confidence in identifying the mental health needs of children they saw and the difficulty of establishing a ‘rapport’ to explore difficulties further. The study concluded that there was a “serious skills gap”. Primary care clinicians also expressed a desire for increased collaboration with mental health professionals.

Beresford, Clarke and Greco (2010) undertook a small thematic analysis study of eleven regular referrers to gain their views on referring to a mental health service for deaf children, followed by a postal questionnaire to all seventy-two previous referrers. Referrals came from a range of community services and included clinicians, social workers and teachers. Services for deaf children with mental health needs were found to be significantly limited. At the time of the study, only three areas provided a deaf specialist mental health service. Beresford et al (2010) found that community referrers felt generic CAMHS services were not equipped to work with deaf children with mental health needs. Referrers expected clinicians to be both expert in working with deaf children and with mental health. They valued the flexibility of deaf CAMHS to see children more quickly, and at home or school if needed. The also welcomed liaison between clinicians and other services such as schools.

Hinrichs (2012) attempted to address a question about whether past experience of referring to CAMHS might influence GPs when they refer in the future. This was in the context of a quantitative study that concluded that GP referrals to CAMHS were three times more likely to be rejected than referrals to other services. Again, GPs noted their lack of confidence to assess mental health needs in young people and to know what CAMHS services might be able to do to support these needs.

Later studies in the UK again considered the experience of GPs referring to CAMHS. O’Brien et al (2017) undertook a research study focusing upon GPs perceptions of CAMHS services in relation to referrals regarding childhood anxiety. In this study, twenty GPs were interviewed and the data analysed using Thematic Analysis. The findings were that GPs felt ill equipped and lacked confidence in managing possible childhood anxiety disorders. This was linked to their lack of training in children and young people's mental health. The study recommended better training for GPs in this area. GPs felt they prioritised mental health difficulties less than physical health issues. They noted concern about the possibility of providing a mis-diagnosis and that parental influence could determine whether a referral to a mental health service was offered. They also experienced feeling isolated and unsupported by specialist services and wanted more communication and collaboration with them.

Lambert et al (2020) studied the experiences of GPs in Lancashire with a specific focus upon the provision of a Primary Mental Health Worker in four of the interviewed GPs surgeries. Nine GPs were interviewed and the data analysed using Thematic Analysis. Findings included that GPs experienced feeling 'stuck' in managing possible referrals for children with mental health needs. Where a Primary Mental Health Worker was available in a GP surgery, GPs felt they were able to discuss referrals which helped them to make better referrals that were more likely to be accepted by specialist services. The findings were also that GPs felt they needed more collaboration with CAMHS. Insufficient communication was experienced and GPs welcomed more training in children and young people's mental health needs.

The findings from O'Brien (2017) Lambert et al (2020) were in keeping with an earlier study by Roberts et al (2013) which focused upon GP experiences of referring 12–19-year-olds with emotional distress to CAMHS. Nineteen GPs in the north east of England with four or more years of experience were interviewed and the results analysed using Grounded Theory. They too reported feeling anxiety about what to do and what was expected of them in relation to assessing and referring young people regarding their mental health. This they said felt like "professional incompetence" (Roberts: 2013: 3). GPs also expressed a concern to not over medicalise emotional difficulties, as well as an awareness of the volume of work being managed by CAMHS. Whilst they expressed a wish to not waste CAMHS clinicians time, they were also concerned about not identifying a more significant mental health concern. Other smaller studies have focused on referral pathways and possible barriers in referring to specialist mental health services (Moorish: 1995; Parmar: 2009).

Outside of the UK, Stanton, Lahdenpera & Braun: (2017) centred their research study in New Zealand and examined the views of a range of referring community clinicians to a mental health in-patient unit. A thematic analysis was undertaken of data from 48 semi-structured interviews with a range of clinicians including psychiatrists, nurses, occupational therapists and social workers. Two of the key findings were a desire for increased communication and collaboration between community and mental health clinicians.

Research studies considering paediatric referrers experiences of referring to CAMHS interventions, were very limited. Slowik and Noronha (2004) analysed survey data from 174 community and general paediatricians regarding their experience of CAMHS services in the West Midlands. Of note was that one quarter of children referred by community paediatricians were aged under seven. Two-thirds of respondents felt they lacked training in managing mental health needs in children. The research also found that paediatricians recommended improved access to CAMHS services, expansion of the number of clinician’s in CAMHS, and better liaison through mechanisms such as joint clinics.

Studies aimed at evaluating pilots to improve collaborative working were also documented. Bulwar and colleagues (2017) evaluated a pilot service named “Thinking Together” which brought together thirty trainee clinicians within CAMHS and Paediatric services. It was encouraging to read innovative examples implementing new ways of working in response to what research had already highlighted in this area. This pilot study was extended to four centres within the UK in 2018 due to the positive feedback that was received. A further paper in 2021 (Cryer & Fisher: 2021) presented the continuation of the programme and noted that prior to the scheme only one third of trainees expressed having experience in either paediatrics or mental health.

The literature review in this area demonstrated evidence of a significantly limited body of research specifically focused on the referring clinicians’ experience of the contribution of a mental health service or intervention. This research study aimed to address this gap in the literature in a small way. Common themes in the existing literature were a need for greater collaboration between referring clinicians and

CAMHS services. There was also a desire for increased communication to provide advice and support to potential referrers. This was linked to the evidence of community referrers feeling they lacked knowledge and training to respond to and assess potential mental health needs within their clinical roles.

The final area of literature I will now move on to consider is online clinical interventions. This was an area that unexpectedly expanded at the time this research study was undertaken.

2.5 Online Therapeutic work

A global pandemic was declared due to the COVID-19 virus during the data collection phase of this study. This had an unforeseen impact upon the delivery of the clinical intervention being provided and researched. On 23rd March 2020, the UK Government announced a series of measures to limit social contact and reduce the spread of infection. The main measure was the introduction of a national lockdown which was gradually eased during May and June 2020. All three children in the intervention cohort attended either Nursery or Reception Year at Primary School and they were required to be home-schooled unless their parents were defined as having key worker occupational status.

The result of these measures on the research study was the implementation of a transition from in-person therapy at the clinic to remote sessions either online or via telephone contact. Providing clinical work at a distance was not an entirely new field of intervention. The field of ‘tele-medicine’ has been in existence since the 1970s (World Health Organisation: 2010). Tele-medicine approaches are aimed at improving health outcomes utilising technology, particularly where there is a geographical barrier present. Their widespread utilisation has been impeded by factors such as cultural, linguistic and technological limitations where there exists a lack of a legal framework across countries, despite the possible cost effectiveness. Examples of tele-medicine in practice included maternity services in Mongolia; breast screening in rural Mexico and an initiative focusing on cardiac illness in Norway. Accounts of online psychoanalytic work had been focused on the ability of online technology to bridge the physical gap between the therapist and patient (Bakalar: 2015; Widdershoven: 2017).

Research papers focusing upon the provision and evaluation of remote or online therapeutic work was evident though limited within the field of under-fives brief therapeutic work. Edwards & Maltby (1998) wrote of the importance of speaking with family members via the telephone prior to their offer of an in-person five-session clinical model. They wrote “the anonymity that a telephone provides allows contact to be made and a confidence built up in a way that does not feel possible otherwise” (Edwards & Maltby: 1998: 116). Improvements were even noted between this initial telephone call and the first in-person appointment. Beebe (2003) undertook a version of brief work utilising clinical observations of the infant and parent/s that were recorded and then watched back within the clinical session. The intervention aimed to evaluate the potential for linking the narrative of the child’s presenting difficulties, with the narrative of the clinical observation in the session to the narrative of the parents’ own experience of being parented. Widdershoven (2017) outlined the possible advantages and challenges of online brief work with children aged under-five and their families living in remote Greek islands.

Drawing upon these studies, I will now outline some of the areas that required consideration as this research study transitioned to an online clinical intervention. Areas considered focused on the establishment of a therapeutic relationship in online interventions, the importance of the analytic framework, the child’s relationship to the technology, the impact upon the transference and the potential drawbacks of the medium.

Lemma (2017:111) acknowledged the importance in having met, and ideally formed a working relationship with the patient, prior to a transition to psychoanalytic work online. This was due to a number of challenges and limitations which in her opinion meant that, “we cannot replicate a fully shared embodied experience in virtual space”. Widdershoven (2017:73) too felt that meeting in person was “essential in developing a positive relationship” to ensure that families were comfortable to work with the psychotherapist online, to discuss how this would work in practice and how the families felt about tolerating a physically distanced therapeutic relationship.

The analytic setting in brief parent-child psychotherapy was as central to the therapeutic intervention as it is to any psychoanalytic clinical intervention. The consistency of a confidential, boundaried and safe clinical space in which unconscious phantasies can be observed was central to the work offered by Child Psychotherapists. Online therapeutic work however fundamentally modified both the setting and the therapeutic process (Lemma: 2017). There were elements of the online brief parent-child intervention that had similarities to an in-person intervention. The first of this was how the parent and child accessed the session. In person this would be by use of a doorbell into the clinic building and remaining in a waiting room until the therapist started the session at the agreed time. In a similar way, online therapeutic work required the parent and child to access the online session by entering a virtual waiting room and waiting to be admitted to the 'session' by the therapist.

The scene that may then be apparent to the therapist could be vastly different to the analytic setting that the therapist would create for the parent and child within the clinic. In brief parent-child work, the clinical room is often arranged with two chairs for both parents, even where one parent is absent, alongside a smaller chair for the child. A limited number of toys were available to the child. In this research study, this included a small number of both wild and farm animals as well as some fences, a tea set laid out on a small table, a dolls house and figures and some paper and pencils. Within the online parent-child intervention, the lack of ability in the therapist to limit what the child and the parent are potentially distracted by in the home environment required negotiation with the parent to try and re-create an environment that resembled a clinical setting.

One potential positive side effect of providing a clinical intervention to families within their homes was the ability to reach some families who may have struggled to regularly access clinic-based sessions. Bakalar (2015) highlighted the benefits of being able to see and hear the mother–infant couple in the natural setting of their home, allowing for the mother to be more comfortable than she might in travelling to a clinic.

During in-person clinical sessions, the therapist would provide a mixture of observing and interacting with the child, whilst listening to the narrative being provided by the parents. In online therapeutic work, there was a possibility that the child could exit the field of vision on screen, resulting in a loss of connection between the therapist and the child. Not only might the child exit the screen and the therapeutic space, but they may also wish to attack the means by which the therapist was entering the family home and their relationships. Widdershoven reflected upon this within her clinical work

> *The small child in the family seems to have a more direct relationship with the computer; he attacks it, and he embraces it expressing how he feels about the treatment, his parents and the therapist. In a recent example, when a four-year-old's parents were trying to think about a recent, difficult incident, the child pulled out the wires from the laptop, cutting the sound completely! (*Widdershoven: 2017: 78)

Due to the physical distance between the therapist, the parent and child, it may be more difficult to read, interpret and ascribe meaningful links to the communication of the child and consider their states of mind. Whilst listening and observing, the therapist makes conscious and unconscious links to their observations and to the narrative being provided by the parents (Emanuel: 2011). When the child's play is off-screen or partially obscured, the ability to work through perceived difficulties within the family by drawing upon the child's unconscious material may be limited. Widdershoven (2017: 77) documented the need for the therapist to not only make use of the "intra-space", the inside space of thoughts and counter-transference feelings, and "inter-space", between the therapist and the parent to think together, within the session. "Cyber-space" also needed to be "thought about, investigated and worked through" particularly the new contexts of physical distance, setting and the use of the camera. Rather than a concern that a lack of counter-transference experiences were evident within online work, Widdershoven (2017) outlined the possibility of very primitive experiences being stirred up in remote working. The result can be a feeling of being the "not good enough therapist".

One common area of criticism regarding the use of online platforms can be the concern about the robustness of the technology to provide a consistent, confidential and accessible therapeutic space for children and their families. The possible lack of control in retaining these parameters online can cause both the therapist and family members to feel anxious. Of course, difficulties can occur regarding in-person therapeutic provision at times, such as clinical spaces being occupied by colleagues, items in therapeutic rooms being moved or removed and unwelcome disruptions of noise or intrusions. The apparent helplessness of the therapist and parent when a technical drop-out causes the therapeutic space to vanish, without any certainty of its return, can bring its own particular type of difficulty to the therapeutic work being to be delivered. Widdershoven (2017) noted that overcoming such difficulties can often be overcome by fathers. In one clinical example provided by Widdershoven, the breaks in continuity in the sessions, elucidated some of the discontinuity that the child had experienced in relation to family separations, losses and the absence of his father.

2.6 Summary

There now exists a growing body of research regarding clinical work with under-fives. There is compelling global recognition and evidence compiled over many decades regarding the vital support that these young children need within their families, and more widely though professional health and educational support where necessary. However, a context of finite resources and a lack of consistent provision of mental health support for this group of young children has remained evident despite the overwhelming body of evidence in relation to what is needed. The result is that some young infants and children continue to be at risk due to their exposure to adversities through factors related to poor parental mental health, domestic abuse and substance and alcohol use. Although various initiatives have been put forward, these young children “are often forgotten about and easily ignored in policy, commissioning and practice” (Parent Infant Foundation: 2019b: 32)

The need to embrace working with young children and their families via online technology due to recent global events created some acknowledgment of what may be possible to provide, alongside the limitations. This need may push the therapeutic community to work towards sharing best practice guidelines as desired by those who have written about the possibilities of such technology to further expand what might be possible in achieving early interventions for young children and their families.

This study aimed to consider the experience of the contribution of a brief parent-child psychotherapy intervention within a paediatric diagnostic assessment. This literature review highlighted the significant gap in clinical research undertaken with this particular focus. This gap in knowledge within the discipline was part of the rationale for undertaking this research study to examine this under-represented, yet important aspect of clinical collaboration with paediatric colleagues.

3 Research Design & Methodology

The aim of the research study was to answer the research question “how do paediatric clinicians experience the contribution of a brief psychoanalytic psychotherapy intervention to the paediatric diagnostic assessment of children aged five and under?”

This chapter will describe the research design used to achieve this aim. I will outline the rationale for the chosen method of qualitative research, the theoretical approach for analysing the interview data and discuss why this method was appropriate to answer the research question. I will describe how the study was set up by gaining ethical approvals, the research sample and its inclusion process, and the recruitment of participants. I will also outline how I set up the research interviews and consider the dual role of clinician and researcher within the study.

I will describe the philosophical framework that underpinned the theoretical analytical method used of Interpretative Phenomenological Analysis (IPA) to analyse the research interview data and consider this in relation to working within a psychoanalytic framework. I will also consider the use of IPA as a method of analysis and its application within this research study before concluding with some reflection on the tensions and limitations within the study design.

3.1 Qualitative research rationale

My research proposal initially developed through discussion within the Research Methods workshop, alongside offering an under-fives brief psychotherapy intervention during my clinical training. At that time, the provision of brief work to very young children by liaising with Paediatric colleagues was a developing area of clinical practice within the locality where I was based in. Many referrals were received highlighting unmet need within this population. In considering this as a possible area of research, I was aware that other clinicians had written widely about the experience of providing a brief intervention from the perspective of the child, parent and Child Psychotherapist but the experience of the referring paediatric clinician had not been written about. There was also no research which considered how the intervention could contribute to paediatric assessments.

I wanted to consider what paediatric clinicians understood about the intervention that was being offered, how they viewed a psychoanalytic focus upon the child's difficulties and what factors led them to consider that a child might benefit in some way from the intervention. Additionally, I wanted to know how their experience of the brief child psychotherapy intervention could impact upon their own clinical understanding of the child's difficulties, and on the referral of any future children.

The rationale for using a qualitative research method was that qualitative research methods are particularly suited to addressing research questions of this nature as "they initially developed in fields of study in the social and human sciences" (Rustin & Rustin: 2019: 10). The experiences of the research participants were the priority

> *Encounters with facts, evidence, and experiences should come first, and theories be their eventual product, emerging as the means of finding meaning in them.* (Rustin & Rustin: 2019: 10)

Qualitative research methods can provide "rich descriptions of phenomena" and "help to identify patterns and configurations among variables and to make distinctions" (Sofaer: 1999: 1102) Both of these aspects I considered important when researching the experiences of the paediatric clinicians.

In addition to qualitative research methods, the research study also used quantitative methods in the form of standardised outcome measures completed by the parents at the start and end of the intervention.

Mixed method studies combining qualitative and quantitative research methods in this way are frequently used in areas of health research as they can help to develop a hypothesis of why a phenomenon may occur, or how an event is experienced, to aid better understanding. In this study, my hypothesis was that the brief parent-child intervention would be beneficial to the paediatric diagnostic process, as well as beneficial to the referred child and their family.

3.2 **Research design**

Drawing upon my experience of providing a brief parent-child psychotherapy intervention during my clinical training, I discussed the possible research design with my research supervisors. I wanted to include within the research study clinical cases of children who had engaged with a brief parent-child psychotherapy intervention and to draw on these clinical cases, as well as interviewing the community paediatric clinicians who had referred them.

This was in order to provide a detailed discussion of the range of difficulties that such an intervention may help with, as well as to provide clinical case material of the intervention being offered and its outcomes. To enable such clinical information to feature within the research design, ethical approval was required to enable anonymised patient data and aspects of the clinical intervention offered to be included. Contextual clinical data regarding the children's referral and the clinical interventions are detailed within the Narrative chapter.

To research the contribution of the intervention for the experience of the referring community paediatric clinician, initially the research design was to incorporate two semi-structured interviews. The first interview would be undertaken after completion of the brief parent-child intervention and a second up to six to twelve months later when the child was subsequently reviewed. This aspect of the study required significant revision which I will detail later in this chapter.

3.3 **Ethics**

As the research study aimed to include anonymised patient data regarding the referral of children to the brief child psychotherapy intervention, ethical approvals were needed from the National Research Ethics Committee (NREC), the University of East London's Research Ethics Committee (UREC) and the local Trust's Research Department prior to the study being conducted.

An initial application for ethics approval via the IRAS system from NREC was requested and declined on 10/11/17 due to further clarity being required about what was a research activity and what was standard care. A substantial delay in the research project then occurred due to the re-commissioning of CAMHS services in the locality in which the research was intended to take place. This resulted in a twelve-month suspension of the research. A subsequent re-application was approved on 11/11/19. UREC approval was given on 13/11/19 and local NHS Trust approval on 19/11/19. Redacted copies are included within Appendix 8.1. and 8.2.

The participants' data has been anonymised throughout to protect confidentiality.

I have considered ethics to be an iterative process within this study in that I have thought about ethical aspects of the study even after ethical approval was granted. When working with a small sample, I considered the possibility that participants may identify themselves, or a colleague, within the data and the importance of anonymising the data. I also reflected upon the position of being in the dual role of researcher and clinician whilst undertaking the clinical intervention with the referred child and their parent. Incorporating the ability for the parent to withhold consent whilst still receiving the clinical intervention reduced any coercion that may have been felt by the parent. Parents were also informed that they could withdraw consent at any time up until data analysis which provided them with approximately one-year to withdraw. I also contemplated the ethical dilemmas that may be felt by the referring paediatric clinician to openly discuss their experiences of their role, service and feelings towards the referred child and parent with another clinician as they may have viewed me, rather than as a researcher.

The design of the recruitment process stemmed from the initial unfavourable NREC opinion which stated that the recruitment of participants should be conducted in such a way as to minimise coercion. The design therefore enabled initial information regarding the research study to be provided by personnel outside of the research study. Additionally, as the clinical intervention was considered routine care, provision of the clinical intervention was not dependent on their taking part in the research.

The parents of the first five children referred to the intervention within the period of data collection, who met the inclusion criteria for the intervention cohort, were asked to consider consenting to the study. Parents and referring clinicians were given seven days to consider providing consent. They were informed that they could withdraw their consent at any time without providing a reason, prior to data analysis. Provision of the brief clinical intervention to the referred child remained unchanged even where a parent may have withdrawn consent. An example of the consent form is included within the Appendix 8.4.

Data included within the research study was stored within NHS secure computer systems and access was restricted to the Chief Investigator. All personal data was treated as confidential in accordance with the NHS Code of Confidentiality guidelines and the Data Protection Act. Research participants were informed of how research data was stored. Data generated from the research study will be stored for ten years in line with local NHS Trust guidelines.

3.4 **Study redesign**

Initially, one area that the study aimed to evaluate was the contribution of the intervention to a learning process. This aspect would have been addressed in a second semi-structured interview with the referring community paediatric clinician six to twelve months after the brief psychotherapy intervention had been completed. This follow-up interview would have also enabled the referring paediatric clinician's experience to be compared with their thoughts about children who had not been referred to the intervention. However, due to delays in gaining ethical approvals and the subsequent time taken recruiting and collecting data, it was decided to remove this element of the research design as it was not possible to undertake in the time frame allowed.

A re-design of the study was considered within research supervision regarding the intended analysis of clinical process note data using IPA within my original research proposal. It was decided not to analyse this data. The rationale for this was that the findings from this analysis would not have enabled me to answer the research question that had been posed. There were also time constraints in analysing data. This clinical data instead fed into the clinical formulation report that was shared with the referring community paediatric clinician, parent and the child’s GP.

A further change to study was required due to the impact of COVID-19 restrictions introduced shortly after the data collection phase of the study had begun. At the start of the study, clinical sessions were offered to the children and their parent/s in person at the local CAMHS clinic building. However, three months into the data collection phase, COVID-19 restrictions meant that in-person interventions were not permitted. Additional ethical approvals were required to enable the clinical intervention to be conducted online. This change partly contributed to a lengthening of the intervention from the originally stated five clinical sessions to allow for an additional further five sessions if required.

Research interviews were also intended to be completed in person. Due to COVID-19 restrictions these too were completed online. Ethics permission was granted for this change to the design. I will consider the potential impact that this method of interviewing may have had upon the research interviews later in this chapter.

3.5 Research sample

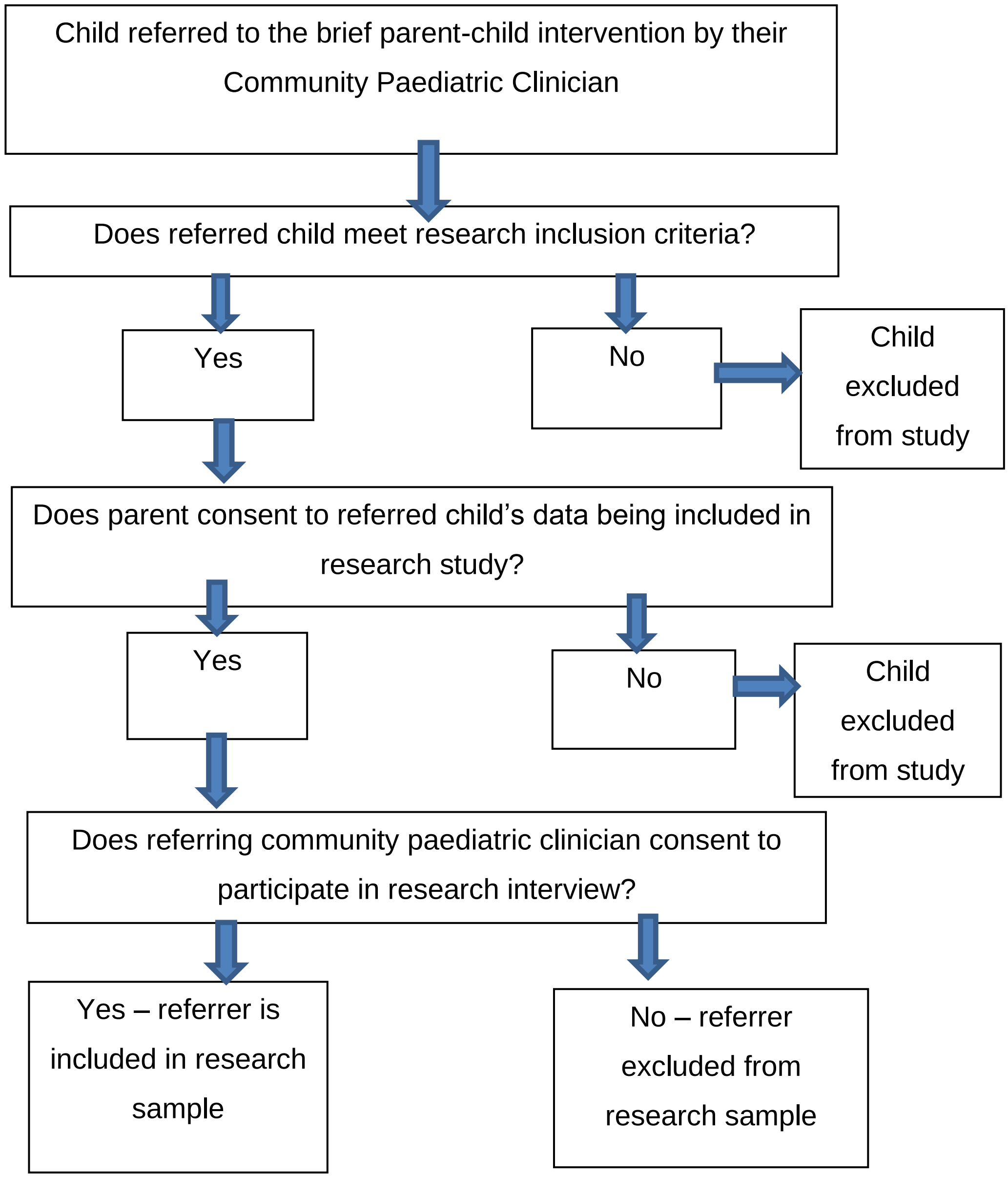
The research participants within this study were the referring community paediatric clinicians. The sample of research participants was recruited only when written consent had been initially provided by the referred child’s parent. I will describe below the intervention cohort of referred children and how these children were identified.

The intervention cohort was identified using the following inclusion criteria:

- A child of either gender aged five or below at the time of referral
- who did not have a neuro-developmental diagnosis at the time of referral
- who was known to the local Paediatric Service
- and had been referred to the Brief Parent-Child Psychotherapy Intervention
- and who had attended at least three clinical appointments
- and where the parent had consented to their child’s data being used in the research project.

A flowchart of the process of recruitment of the sample of referring community paediatric clinicians is below (Figure 1):

Figure 1: Flowchart of recruitment to research sample



A sample of data relating to five children was considered large enough within the time constraints of the project. Qualitative research based on small sample data is idiographic in its approach as it is aimed at illuminating in detail what the experience of certain phenomena was for that individual. Despite small sample sizes, such research studies can highlight similarities and differences in experience.

As the research was based upon a routine clinical intervention for all children aged under-five years old who were undergoing a diagnostic assessment by Paediatrics, children with a neuro-developmental diagnosis continued to be offered the brief intervention but were not included within the research study. The reason for this exclusion was based on previous experience of offering a brief parent-child intervention in a previous clinical setting where children diagnosed with a neuro-developmental diagnosis were typically discharged from the Paediatric Service meaning a research interview with the referring clinician would not have been possible.

From the intervention cohort of five referred children, up to five referring community paediatric clinicians formed the research sample providing data via a semi-structured interview of their experience of the contribution of the brief psychotherapy intervention offered to the child they had referred.

3.6 **Recruitment**

The referring community paediatric clinician informed the child's parents at the time of making the referral, that a research study was being conducted and asked them to consider giving consent for their child's anonymised data to be used.

During the period of recruitment (January-March 2020), nine referrals to the brief parent-child psychotherapy intervention were received. Of these nine referrals, five met the inclusion criteria for the study. Of these five, four parents consented to their child’s data being used within the study. The parents who consented to data about their child being included within the study are presented in the table below (Figure 2):

Figure 2: Table of children referred to the brief intervention whose parent provided written consent

Participant	Referred by	Gender	Age at referral	No of sessions attended (in-person/online)
Archie	Speech and Language Therapist A	M	4 years and 10 months	2 / 6
Bonnie	Occupational Therapist A	F	4 years and nine months	3 / 4
Carl	Speech and Language Therapist B	M	3 years and nine months	1 / 4
Darcey	Speech and Language Therapist C	F	3 years and seven months	0 / 3

All four parents for the four eligible children referred during the data collection period provided written consent.

A decision was subsequently reached within supervision to exclude Darcey's data from the research study due to a change in circumstances during the intervention resulting in a family court intervention. I later reflected upon the exclusion criteria and whether I should have considered excluding any child for whom there were safeguarding concerns or care proceedings, although this would not have excluded Darcey from the research study as it was only as the intervention progressed that this development occurred.

The three referring community paediatric clinicians were recruited to the study following completion of at least three clinical appointments with the referred child and their parents. A clinical formulation report was provided to the referrer, the parent and the child's GP. Anonymised copies of the report are included within Appendix 8.8. Referrers were provided with a written Clinician Information Sheet (CIS) detailed in Appendix 8.5 and written consent was requested (Appendix 8.6). Of the potential sample of three referring clinicians, all three provided written consent to participate in a semi-structured interview.

3.7 **Data Collection**

Three types of data were collected during the research project. First, standardised outcome measures; second, semi-structured interview data of the referring paediatric clinician and finally, field note data.

Standardised outcome measure data

Standardised outcome measure data collected through the completion of routine service questionnaires by the parent were analysed to track potential changes in their perceptions of the child's functioning at the start and the end of the intervention. The outcome measures collected were Goal Based Outcomes, Strength and Difficulty Questionnaire and Experience of Service questionnaire.

Semi-Structured Interview Data

For the children whose parents consented to the study, consent to interview the referring community paediatric clinician regarding their experience of the parent-child intervention was sought. These interviews were not part of the routine clinical service and were carried out for the purposes of the research study.

A semi-structured interview was chosen for its ability to allow a space for the interviewer and participant to think, speak and listen in an in-depth manner. Britten (2000:12) defined a semi-structured interview as "a loose structure consisting of open-ended questions that define the area to be explored". Smith, Flowers & Larkin (2012: 58) stated that a schedule enabled the researcher "to anticipate potential sensitive issues and to frame her questions in suitably open forms." The interviewer and interviewee work in collaboration to identify and interpret the relevant meanings that contribute to the experiences being researched. In this way, the qualitative interview should "try to be interactive and sensitive to the language and concepts used by the interviewee". The aim of the semi-structured interview was to "go beyond the surface of the topic discussed" (Britten: 2000:13).

Patton (1987) said that there were six areas that semi-structured interviews may ask about. These were behaviours or experiences; opinions or beliefs; feelings; knowledge; sensations and background. In this study, the main aim of the semi-structured interview was to elicit information about the experiences of the referrers. In doing so, background knowledge, experiences, opinions and feelings were all considered important. An initial question was asked about the referrer’s own clinical area of expertise based on “the importance of starting with safe, unthreatening questions in the interests of developing rapport” (Hollway et al: 2013: 28) or as Smith et al (2012: 59) stated “to start with a question which allows the participant to recount a fairly descriptive episode or experience”. The interview schedule then went on to focus on four areas of questioning – prior awareness of the brief child psychotherapy intervention for children aged under five; experiences of the referral process; paediatric reviews of the child referred and potential impact of the brief intervention on future clinical practices.

The study aimed to consider how the referrer experienced the contribution of the routine brief parent-child intervention for the referred child, within the wider diagnostic paediatric assessment of children aged five and under. The clinical formulation report allowed overlaps or divergences in clinical opinion to be considered.

Due to national COVID-19 restrictions in place at the time of the research, NREC approval was gained for the semi-structured interviews to take place online. Alase (2017) stressed the importance of enabling participants to choose the date and time of the interview to ensure their comfort. The interview lasted up to one hour and was recorded to aid transcription. Smith et al (2012) recommended scheduling each interview with enough time to conduct and transcribe one, noting initial thoughts, and then move onto conducting the next interview. I carried out three interviews between March – May 2021.

Although clinical formulation letters detailing clinical interventions were routine within clinical work with children and their families, the clinical formulation report took on an additional significance as it was the bridge between the referred child and the clinical intervention. Without a detailed clinical account of the work undertaken, the interviewee may have struggled to conceptualise what had taken place during the brief parent-child intervention that they were now being asked their views on.

After providing each of the three referring clinicians with a clinical formulation report, I contacted each clinician to ask if they would consent to participating within the research study. Initially no responses were received. I subsequently provided an update on the research study to the paediatric diagnostic pathway leads highlighting that I was now seeking consent from the referring clinicians to be interviewed. Again, no response was received. Attempts to speak to the individual referring clinicians was met with a gatekeeping receptionist who advised me to continue to email the clinicians directly and that direct telephone numbers for these clinicians could not be provided to me.

I reflected upon my experience of trying to contact the paediatric referrers and the possible reasons for the obstacles to this. I was aware via the parents of two of the children in the intervention cohort that paediatrics had discharged their referrals. I wondered whether the value in the intervention was to be a place to refer children onto with little interest in what happened next for them. Within clinical supervision, I reflected on how during my initial research design I had intended to interview referring clinicians with an expectation that they would be reviewing the referred child again, yet the research study found that two of the three referred children would not receive such a review. I therefore persevered in continuing to contact the referring clinicians by devising emails that continued to emphasise the joint thinking around the referred child and the interview being an opportunity to reflect on the brief parent-child intervention building on a foundation of support already provided to the referred child by paediatrics.

In securing consent for the interview with the first clinician, I began to understand why there was no initial response to the request as the clinician admitted being unable to recall the referred child. The second and third interviews followed fairly quickly: Clinician 1 acted as a broker between Clinician 2 and Clinician 3 in securing the interviews, partly influenced by their own reported positive experience of the interview, in conjunction with a fear being allayed about the time commitment involved. Two of the participants also commented on their anxiety about what they might be asked during the interview. Further complications were experienced in reaching Clinician 3 as they had temporarily left the paediatric department.

Undertaking research interviews was a new area of professional development that I experienced within the research study. Holding the dual role of researcher and clinician has been an area of research and a review of thirty-six studies considering this aspect of clinical research was undertaken by Hay-Smith et al (2016). Advantages and considerations were identified including clinicians being able to undertake research with relevance to their discipline; having access to research participants that a non-clinician researcher may not have; a foundation of possible trust for those who do participate; alongside the motivation and commitment to continue work in the clinical area following completion of the study. Some of the areas of difficulty included confusion both externally and internally regarding being in the dual role; feeling over identified with one of the roles and needing to balance the clinical role with the research participants needs whilst adhering to rigorous research methods.

One advantage of my dual clinician-researcher role was that I was able to gain access to the research participants I wanted to research. Through the provision of an under-five's intervention, I facilitated working relationships with clinicians in the paediatric service enabling this research to be possible.

When analysing the semi-structured interview data, I also reflected on my own anxieties to fulfil the role of the researcher, as well as continuing to be in the role of a clinician discussing a child with another clinician working within the same clinical locality. Smith et al (2012: 58) stated that “a good interview is essential to IPA analysis”. To achieve this “both interviewer and interviewee are active participants within the research process.” Anxieties held by both the interviewer and interviewee can impinge on the interview dynamics. Hollway et al (2013: 31) acknowledged this dynamic within the interview process “a combination of the unfamiliarity of the (first-time) situation and developing worries about the success of the interview after high expectations of it” can be present in research study interviews.

The dynamics within the research interview process can be akin to processes at play in clinical work

> *We intend to construe both researcher and researched as anxious, defended subjects, whose mental boundaries are porous where unconscious material is concerned. This means that both will be subject to projections and introjections of ideas and feelings coming from the other person. (Hollway et al: 2013: 41).*

Patton (1987) defined the degree to which a researcher may be “nondirective or directive” within the interviewing process which he felt ranged from making encouraging noises as the least directive and introducing a new topic into the interview as the most directive. Each research interview could be considered in a similar way to undertaking psychoanalytic clinical work. It is important for the researcher, like the clinician, to be aware of the impact of the researcher’s role upon the research interview, as well as the nature of the relationship between the interviewer and interviewee

> *…the resulting narratives are always a product of the relationship between interviewer and interviewee…the dynamics of the interview pair and their importance for the production of data. (Hollway et al stated: 2013: 41).*

Field & Morse (1989) described how an interviewer can feel a loss of control during the interview process, such as interruptions or competing distractions. In one of the interviews, I was aware of a competing distraction when the interviewee informed me that their infant child was sleeping next door and that they were waiting for an important telephone call at the start of the interview. I felt this created a sense of pressure to complete the interview more quickly. During the transcription of the interviews, I was also aware of the more direct, short answers that were provided and at times they lacked the elaboration of experience, opinion or feeling that I considered to have been included within the other two interviews. however, if the interview had not taken place within the interviewee’s home environment with these competing distractions, the interview may not have been possible due to the clinician’s personal circumstances.

Field note data

Field note data was recorded whilst setting up and conducting the research study. This enabled me to reflect on processes such as the ethics approval process, as well as clinical and research supervisions during the study. During the data collection phase, I made notes in my field journal after each interview to enable any initial thoughts about the interview to be considered before moving onto the next interview. I have drawn on my field note data throughout this and the Concluding chapters.

3.8 Analysing and managing data

Why IPA?

Following completion of the data collection, analysis and interpretation of the interview data from the referring paediatric community clinicians took place using IPA.

In deciding which analytical method to adopt, I considered other qualitative approaches through the support of the Research Methods workshop. This included considering the use of Grounded Theory and Thematic Analysis to analyse the data. Rustin (2019) considered Grounded Theory and IPA to hold similarities

> *the analysis of clinical data with each of these methods involves the elucidation of conscious and unconscious meanings and intentions, within transference–countertransference relationship. (*Rustin: 2019: 170)

As Rustin & Rustin (2019:19) summarised

> *Both [Grounded Theory and IPA] are highly attentive to the particularities of experience, of personal interactions, and of cases seen as integral wholes. Both recognize subjective experience to be complex and hold that its layers of meaning need to be investigated in depth and in detail, usually with small data samples. Each recommend that researchers immerse themselves in their material and investigate it slowly and meticulously.*

This view was also held by Smith et al (2012: 32) who stated that IPA was “concerned with the detailed examination of human lived experience.” Rustin & Rustin (2019: 20) support this view as they stated that

> *IPA has a correspondingly different emphasis from Grounded Theory. Its purpose has been to capture the experience of subjects, in all their complexity, rather than to develop generalizing theories about them. Its interest is in explicating patterns of meaning, rather than determining structures of cause and effect.*

Thematic analysis was also considered as an analytical method through its approach in focusing on “identifiable themes and patterns of living and/or behaviour” (Aronson: 1995: 1). Braun & Clark (2014) developed thematic analysis to use coding of data to identify emerging patterns. From the coding of data, themes are derived from patterns such as "conversation topics, vocabulary, recurring activities, meanings, feelings, or folk sayings and proverbs" (Taylor & Bogdan: 1984: 131). The themes are then brought together to provide a “comprehensive picture of their collective experience” (Aronson: 1995: 1).

I thought the suitability of IPA for studies with a small sample, such as this research, was relevant to my choice of methodology. Analysis of the interview data using IPA centres upon the verbatim accounts given within the semi-structured interviews, enabling an 'insider's perspective' to be evaluated. The interviewer's role is to interpret and make sense of these experiences and to illuminate them in a way that answers the research question that has been posed. The outcome of this process will be a set of themes, which may represent commonalities and variations derived from the data collected.

I concluded that IPA offered the opportunity to examine in-depth the referring paediatric clinician’s perceptions, thoughts and feelings regarding their experience of the contribution of the brief child psychotherapy intervention for the child they referred. As the experiences of the referring community paediatric clinician was central to the research question that was posed, I favoured an IPA approach over Grounded Theory or Thematic Analysis. As this methodology was new to me as a novice researcher, I read widely to ensure that I utilized the approach correctly (Smith: 2011; 20011b; Nizza: 2021), as well discussing with peer researchers and participating in an online IPA research forum.

IPA is based upon three theoretical perspectives – phenomenology, hermeneutics and idiography. It was initially presented as a research approach by Smith (1996) as a psychological approach to "capture the experiential and qualitative, and which could still dialogue with mainstream psychology" (Smith et al: 2012: 4). Phenomenology is a philosophical approach to the study of experience as humans within our lived world. In particular, Smith et al: (2012) state that the contribution of philosophers, such as Edmund Husserl were significant in their contribution to and development of phenomenology. Husserl advocated the detailed examination of human experience to enable the identification of "the essential features of that experience" as a means of understanding how "experience would *transcend* the particular circumstances of their appearance and might then illuminate a given experience for others too" (Smith et al: 2012: 12). He asserted that it was crucial to go back to the 'things' themselves to understand this experience.

Hermeneutics is the study of interpreting human behaviour. Within IPA, the researcher attempts to make sense of the research participant, who is making sense of the 'thing' or experience. In a sense the researcher is like the research participant trying to understand the experience. Yet in another sense they are not the same, as they only have access to the research participant's experience through their report of it rather than the experience itself. This approach can also be considered from a hermeneutic perspective of 'empathy' or 'suspicion', with a psychoanalytic interpretation of experience considered to fall into the latter in Smith et al's (2012) view, as it attempts to 'draw out' the meaning of the experience. Smith et al continued to assert that successful IPA within research combined both stances of understanding the participants' experience by standing in their shoes, whilst also "wanting to stand alongside the participant, to take a look at them from a different angle, ask questions and puzzle over things they are saying" (Smith et al: 2012:36). In navigating these differing levels of analysis, the researcher must always be grounded in the research data.

Finally, idiography is the study of the particular and concern for detail and depth which suits a psychoanalytic research approach and can enable researchers to move from the particular to the more generalised.

Initial analysis (Analysis A)

The first stage of analysis using IPA was to “immerse oneself in some of the original data” to “ensure that the participant becomes the focus of the analysis”. (Smith et.al: 2012: 82).

Analysis A involved four stages:

1. Firstly, I recorded my initial thoughts and feelings immediately after the interview.
2. Secondly, as I had audio recorded the interview I listened to the interview as I transcribed the data. Although transcription was time consuming, the value in this exercise was being able to consider the pace and tone of the interview. Non-verbal data could also be captured such as hesitations, laughter, and repetition of sounds. As I transcribed, I recorded any responses I had to the interviewee’s responses, as well as noticing more of the inter-play between myself in the role of the interviewer and the interviewee. Repeated reading and listening allowed me to ‘bracket off’ my initial preconceptions to the data. Listening to the audio data also enabled me to further reflect on my dual role as a clinician and as a researcher and the inter-play between the two positions throughout the interviews, the building of rapport and the development of more complex responses from the research participant.
3. Thirdly, I re-read the transcript of each interview after all three interviews had been completed and added to the commentary.
4. Finally, I re-listened to the audio recording of each interview after all three interviews had been completed and added to the commentary.

2nd stage of analysis (Analysis B)

The next stage of analysing the data was described by Smith et al (2012) as initial noting which involved examining the data through the language used by the participant by adopting a "free textual analysis" (Smith et al: 2012: 83) through close analysis of the text to move beyond initial and superficial expectations of the data. From these analytical comments, Smith et al (2012) expected the researcher to produce a "core of comments". This core will describe the objects, processes, or values for example, that mean the most to the participant. The next stage was to consider how and why the participant held these concerns or interests through examining their language, the context of their world, as well as identifying abstract concepts that help to make meaning. It was suggested that the researcher moved through the data noting "similarities and differences, echoes, amplifications, and contradictions" (Smith et al 2012: 84).

I therefore initially analysed the data via a line-by-line analysis considering what the language and context may mean to me, and what they may mean to the participant. The use of Microsoft Excel to help manage small scale IPA studies has been recommended. I used this software to help design a line-by-line format to consider the transcribed material in greater depth. Appendix 8.9 provides an example. Within IPA, this approach was initially structured by considering the descriptive, linguistic, and conceptual comments within the data. The meaning for the research participant was considered which provided "interpretive coding". I noted significant phrases or language in red text and the use of pauses, hesitancy, and emotional reactions, such as laughter. I created a third column to capture 'Feelings or Experiences' in the data and created a fourth column to record the 'source' of this. Sources used were content of data, language or delivery of language and researcher response.

Coding enabled a more abstract consideration of the data whilst also ensuring that, "the thread back to what the participant actually said and one's initial response" was present (Smith et al: 2012: 68). Smith et al (2012: 90) also recommended deconstructing the data to "avoid focusing upon simplistic readings of what you think the participant is saying". They suggested deconstructing the data one line at a time and approaching the data in reverse by printing these feelings and experiences onto paper, cutting them line by line and placing them on a large piece of paper. This initially felt at odds with the technological capabilities I had available to me to order and re-arrange the data. However, my initial attempt to re-order the data into emergent themes via a computer did not enable me to take more of a step back from the data and consider it in a new way of looking for similarities and differences, noting what feelings and experiences appeared isolated from others and seeing how some feelings and experiences could be more naturally grouped together. The size of some of the groupings, and then the process of considering the emergent themes was more possible by using this hands-on approach to re-assemble the data from the chronological list as it had started. Through this process, I felt that the ‘voice of the participant’ returned, demonstrating the hermeneutic process evident within IPA. Viewing the data in this way also enabled me to look at the data with a new lens, rather than becoming too familiar with the flow of the interview data.

This process also involved moving away from considering the interview data for each clinician in its entirety and towards breaking up the data into fragments of the clinician’s experience. This process within IPA was a part of the “hermeneutic circle” as described by Smith et al (2012). Central to this process was my role of interpreting and as such, the researcher becomes more included within the analysis of the interview data, whilst still retaining closeness to the original transcript data.

3rd stage of analysis (Analysis C)

The next stage of analysis was not considered to be prescribed within IPA and enabled the researcher to explore or analyse the data with a view to identifying “emergent themes” (Smith et al: 2012: 91). Not all emergent themes would be retained and may be dependent upon the research question to be answered. The research question posed within this study was to consider the contribution of the intervention being offered so this had some bearing on what themes were included to answer this.

One suggested way of considering connections within the data was to create a chronological list of all the feelings and experiences of the research participants. Data from each participant produced its own unique chronological list. The data from Clinician 1 created one hundred and thirty ‘feelings or experiences’; from Clinician 2 one hundred and ten were created and from Clinician 3 seventy-two. In total the data set now included 312 interpretations of the three research participant's wishes and feelings. A partial example of one of these chronological lists is below (Figure 3):

Figure 3: Excerpt of chronological research participants feelings or experiences

Clinician 1	Clinician 2	Clinician 3
Skilled clinician	Uncomfortable to consider their own role	Experienced working with young children
Needed by team	Adaptable	Loyal to service
Surprised by length of commitment	Willingness to learn	Adaptable to changes
Gratitude to service	Team player	Inexperienced in CPT
Happy in role	Values improving others' lives	Gratitude to intervention
Supported by team	Wants to help others	Struggles to remember referred children
Limited in experience	Enjoys working with young children	Relieved to have intervention
Insecure in experience	Values security of role	Confident in decision to refer
Knowledgeable	Content in role	Keen to help parents
Experienced clinician	No experience of CPT	Understanding of child's needs
Lacks confidence	Empathy with children with additional needs	Uncertain about referred child
Developing an understanding	Gratitude towards interventions	Disinterested in what happened next to referred child
Disempowered in role	Keen to explore working with CPT's	Wants parents to have post diagnostic support
Needs to be convinced	Limited understanding of CPT	Unable to meet the child's needs

The third stage of IPA analysis was the consideration of developing emergent themes. The process of identifying emergent themes reduced the volume of data that had been created whilst not losing its complexity. This was achieved by working primarily with the interpretative comments about the participant's feelings and experiences derived from the second stage recordings, rather than the original interview transcript. The main aim of identifying emergent themes was to take the researchers initial noting and interpretation of experiences and feelings and produce a "concise and pithy statement of what was important in the various comments attached to a piece of transcript" (Smith et al: 2012: 92). The themes therefore reflect not only the participant's original words but also the researcher's interpretation of these.

Emergent themes were identified by searching for connections across an established set of themes (initial noting and interpretation of experiences and feelings) and then to group into clusters that appeared to belong together or have some connection. I adopted Smith et al's (2012) approach of manually re-ordering a printed version of the data. This involved creating printed versions of the established set of themes and moving them around a large board to consider how they related to each other. Smith et al (2012) suggested a number of mechanisms which researchers could utilise to assist this task. I drew on "abstraction" which was the process of identifying patterns between emergent themes and developing what was referred to as a "super-ordinate theme"; "subsumption", the process whereby an emergent theme acquired status as a super-ordinate theme as it brought together a series of related themes; "polarization", which I utilised to consider oppositional relationships between themes to consider difference as well as similarity; and "numeration", which helped me to consider themes in terms of their frequency being supported by the transcript.

Next, I grouped feelings and experiences into emergent themes in turn from each data set for the three research participants. My experience of this was that some aspects of the data naturally clustered, for example into aspects relating to the intervention, however the emphasis of some aspects were more evident for some research participants and not others (Figure 4):

Figure 4: Identified Emergent Themes

Clinician 1	**Clinician 2**	**Clinician 3**
Clinician's strengths and shortcomings	Clinician's values and qualities	Clinician's thoughts on their role and service
Opportunities and obstacles in the Paediatric Service	The need to communicate with other professionals	The importance of joint working
Wanting to understand the child better	Pressure to see so many children	Surviving Change
The pressures when working with parents	What I'm trying to achieve in my role	The pressures when working with parents
Uses of discharging children	View of Paediatric service	What Child Psychotherapy means to me
Parental pressures to diagnose	Working with parental pressures	Having an alternative? The benefits of intervention
Importance of working together	Is it trauma or ASC?	How can the intervention help me?
How can the intervention help me?	Role of diagnosis in managing pressures	View of the referred child
Openness to learning	I want to help the child be understood	
View of the contribution of child psychotherapy	Working with others	
View of the referred child	Learning from child psychotherapy	
	Experience of the contribution of the intervention	
	Referring children to the intervention	

	What was the contribution of the intervention?	
	Role of prevention through the use of the intervention	
	Affirmation of clinical view	

This process produced quite a large number of emergent themes with many areas of overlap across the participants' themes. To begin the process of identifying salient themes across the data, I constructed an Excel table to identify the lines of transcription which supported each of the emergent themes. Data taken from the research participant's data identified as "Clinician 1", "Clinician 2" or "Clinician 3" were coded as C1, C2 or C3 followed by the transcription line count. Smith at al (2012) proposed that this process enabled the researcher to consider the internal consistency, broadness and specificity of each of the emergent themes.

This process helped me to both expand and reduce the number of themes identified. For example, the theme of the participant's view of the referred child was subdivided into 'wanting to understand child better'; 'wanting to improve child's life'; 'holding some children more in mind' and 'referred child'. Other themes were reduced through grouping similar themes together such as 'collaboration' being an umbrella theme for 'joint working'; 'working with others'; 'learning'; 'communication' and 'view of child psychotherapy'.

4th stage of analysis (Analysis D)

Having identified the emergent themes from each of the research participant's data, the final stage of analysis was to identify patterns of themes across the research participants and to identify super-ordinate themes that over-arched all the research participants experiences.

Through this process I considered how one theme may elucidate another theme e.g. themes concerned with the barriers or obstacles in meeting a child's needs identified within the paediatric service may be considered within the theme of the participants motivation to refer a child to the intervention. The super-ordinate themes were identified as (Figure 5):

Figure 5: Table of Super-ordinate and subordinate themes

Type of theme	Name of theme
Super-ordinate theme 1	***"A whole massive resource that we can tap into. It's brilliant!" - Working as a Community Paediatric Clinician***
Subordinate theme 1	"I haven't really looked back since" - Paediatric clinicians' perceptions of their role
Subordinate theme 2	"They come to us wanting a bit of a magic wand" - Working within clinical and organisational limitations
Super-ordinate theme 2	***Paediatric Clinician's view of child psychotherapy***
Subordinate theme 1	"Sounds like a good link we could have now" - Collaborating with Child Psychotherapy
Subordinate theme 2	"It's like looking through a different profession's eye" **–** A mechanism for learning
Super-ordinate theme 3	**"A breath of fresh air" -** ***Experiences of the brief parent-child psychotherapy intervention***
Subordinate theme 1	"Influencing those next steps...rather than going round and round in circles" Reasons for accessing the brief parent-child intervention

Subordinate theme 2	"Your stuff trumps our behaviour stuff!" Identified benefits of the parent-child intervention
Subordinate theme 3	"If I had a family, I'd recommend it!" - Future use of the intervention

Experience of analysing using IPA

Having initially spent time transcribing and familiarising myself with the research participants' responses, the first phases of analysing the data left me feeling removed from the experience of interviewing and focused more on how I interpreted the responses given by each of the participants. Moving to ordering these in chronological lists provided me with three long lists of what appeared at times quite disconnected, disparate phrases which I had used to identify the participants' 'feelings and experiences'.

As a novice researcher using IPA to analyse data for the first time, I found that I needed to trust in the process that I was learning to enable themes within the data to reveal themselves in some way. Given that the focus of the research was considering the experience of the referrer's use of the brief parent-child intervention, I was surprised to find themes relating to the referrer's role and experience of the paediatric service came to the fore. I began to understand this as a way to understand the context in which the referrer approached their level of engagement with the brief intervention and therefore this became a super-ordinate theme from the data. Despite the research being about an area of service development, what was also striking was the emotionality of the clinician's language within the data. Clinicians voiced professional anxiety about the difficulties of managing both the organisational pressures of working with a diagnostic paediatric model, as well as the pressure they experienced from some parents who were seeking a diagnostic answer to their child's difficulties. They spoke of the experience of balancing the differing needs of the child and their parents. There was evidence that experienced and well-intentioned clinicians at times struggled to always meet the demands and complexities of the work being undertaken.

Reflecting on my experience of using IPA within this research helped me to consider that there were some types of research data that might be more suited to analysing via IPA than others. Within the three interviews I conducted, two research participants engaged more openly in talking about themselves, their experience of working with pre-school children and how they experienced the brief intervention. Through this experience, I concluded that research interview data that produces rich, personalised data that reflected on an individual's psychological experience of a phenomenon personal to them, such as a life event, would be well suited to this analytic approach.

3.9 Reflexivity

Reflexivity is the necessary examination of the researcher's own beliefs, judgements and practices present during the research process and the importance of considering the potential impact and influence that these may have upon the research study. In essence, the researcher also becomes a subject to be examined within the research process.

Psychoanalytically trained clinicians are aware of the need to examine their own responses within their clinical work and the impact that this may place upon the patient. Within this research, I held the dual role of providing a clinical intervention to the referred child and their parents, followed by the role of researcher by conducting a research interview with the referring clinician. Within the researcher role, I was also partly viewed in my clinical role as a colleague within the field of child health by those I interviewed. Considering the role of reflexivity within research studies had a natural appeal as I began to read and consider more about the duality of the role, and its specific application within this study. The duality of the role required inhabiting from the start of designing and setting up the study. Discussions related to the study design with research supervisors and child psychotherapy colleagues led me into a new experience of seeking ethical approvals and needing to inhabit the language and understand the lengthy processes necessary to undertake research. This became very apparent following my initial ethical approval application, the reasons for its unfavourable opinion and the subsequent need to distinguish the routine clinical aspects of the study from the research elements.

Speaking with my paediatric colleagues about the research study, and their potential involvement within this, was the beginning of my outward facing role as a researcher. The design of the research required me to move in and out of the researcher role, returning to inhabit the clinician role during the delivery of the brief parent-child intervention.

Conducting semi-structured interviews with referring paediatric clinicians required the researcher role to be at the fore. Arrangements were also needed to undertake the interview of the referring clinician online. I was initially concerned that this method of data collection could be more “detached, impersonal and impoverished” as a way of communicating with the research participants (Jowett, Peel & Shaw: 2011). These researchers have shared their view of interviews needing additional time; the difficulty of technological issues; the presence of distractions and a lack of comfort that research participants may experience talking on screen. As there had been a period of more than one year of the paediatric clinicians moving to working online in their clinical role, I reflected that some of these concerns had been reduced due to the fact that they had become accustomed to working online. Due to the busy nature of their roles, I also felt that that the flexibility of being able to undertake the interview online may have contributed to all the research participants consenting to the interview.

Despite qualitative approaches, such as semi-structured interview data, often being considered a more appropriate research method of finding out the ‘how?’ and ‘why?’ questions in relation to a research area, Hollway et al (2013) suggest caution in this assumption

> *Treating people’s own accounts as unproblematic flies in the face of what is known about people’s less clear-cut, more confused and contradictory relationship to knowing and telling about themselves…. If we wish to do justice to the complexity of our subjects an interpretative approach is unavoidable. It can also be fair, democratic and not patronising, as long as this approach to knowing people through their accounts is applied to the researcher as well as the researched as long as researchers are not seen as neutral vehicles for representing knowledge in an uncontaminated way. (*Hollway et al: 2013: 3)

Hollway et al (2013:24) discussed the complexities of interpreting interview data due to the presence of “defended subjects”. They stated that research participants

> *…may not hear the question through the same meaning-frame as that of the interviewer; are invested in particular positions in discourses to protect vulnerable aspects of self; may not know why they experience or feel things in the way that they do and are motivated, largely unconsciously, to disguise the meaning of at least some of their feelings and actions. (Hollway et al: 2013:24)*

Hollway et al (2013) also suggested that a psychoanalytic model of knowledge placed primary responsibility on the psychoanalyst’s own involvement in understanding a patient. In applying this model within a research interview, they suggested that the researchers own involvement must also be examined to help understand unconscious and conflictual forces.

Hollway et al (2013) had written about the importance of qualitative researchers understanding the role of the interviewer in the production and analysis of interview data. They refer to this as “unconscious intersubjective dynamics” (Hollway: 2013: 4)

> *We cannot be detached but must examine our subjective involvement because it will help to shape the way in which we interpret the interview data. This approach is consistent with the emphasis on reflexivity in the interview, but it understands the subjectivity of the interviewer through a model which includes unconscious, conflictual forces rather than simply conscious ones*.

To enable me to successfully inhabit both roles clinician and research roles, I decided that clinical supervision of the intervention being undertaken with the children and their families needed a separate space from the research supervision I was also receiving. At times, these two spheres came into contact, such as deciding when not to include data regarding one eligible referred child within the research study. Regular receipt of research supervision enabled me to discuss and reflect on my experience of the interview process with each participant.

This chapter has presented how the study was designed, the necessary ethical approvals gained, followed by a detailed consideration of the stages of recruitment, data collection and analysis undertaken to fulfil the aim of answering the research question posed. The next chapter will present a clinical narrative of the brief parent-child intervention undertaken with the intervention cohort of the three referred children and their parents.

4 Clinical narratives

The rationale for providing a summary of the clinical intervention with each child in the form of a shortened case study here was to first illustrate the nature of the presenting difficulties that the child was referred for, and second to provide a summary of the sessions that were completed. The clinical formulation that was derived from the intervention with the referred child and their parents is provided in Appendix 8.8. The difficulties in presenting summaries derived from process note data must be acknowledged due to the difficulties surrounding the selection of material to be presented. In an attempt to address this, I have focused the case summaries upon the areas of difficulty that the child was initially referred for.

Based on the clinical intervention summarised below, a clinical formulation report was sent to the referring clinician, parent, and child's GP. The report provided the referrer with a link to the nature of the intervention, how the referred child and parents engaged with the sessions offered, the focus of the sessions based on the referrer's concerns, the outcome, and recommendations. Each referrer was provided with a clinical formulation report prior to the semi-structured interview. Knowledge of the report formed part of the research questionnaire with an aim of understanding what the referrer thought of the intervention offered to each referred child and their parents. Providing a clinical formulation also enabled further thinking with the referrer regarding how this formulation may align or differ from their own.

4.1 Case Study One – 'Archie'

Archie was referred to the brief parent-child psychotherapy intervention when he was four years old. He was White British and lived with his parents and one younger brother, Daniel. He was referred due to concerns about his very anxious behaviours when going out of the family home, particularly when travelling by car. As well as resisting transitions from home to outside, he also found transitions within the day difficult, such as day to night-time and changing clothing. After a short period of being toilet trained, Archie had also been having frequent soiling accidents.

As with all the children in the intervention cohort, Archie had initially been referred to paediatrics and an assessment of his social communication needs had been completed. Paediatrics concluded that Archie did not meet the criteria for Autistic Spectrum Disorder. He was diagnosed with anxious behaviours impacting on his daily life, a phonological speech sound disorder and mild sensory processing difficulties. Follow up by paediatric physiotherapy and speech and language therapy were provided. Following his referral to the brief intervention, eight brief parent-child psychotherapy sessions were attended. They centred on Archie's anxieties and rigidities, toileting, and experience of transitions.

Archie attended his first clinical session in person with his parents. My first impressions were of an attractive family where there was a relaxed, if possibly somewhat enmeshed feel

> *I see Archie sitting on his mother's knee reading a hard backed book. Everyone appears to be engrossed in this activity. The family appear like they are sitting on their sofa at home, not in a new environment in the clinic…. He has a small well-worn blue teddy bear with an attached blanket wrapped around his right hand, almost like a bandage….He has short fair-brown hair and large brown eyes…In the room, Archie moves around the table and holds his teddy and cloth to his mouth. He appears like a young toddler, using the blanket as his anchor and he holds himself together by this, rather than sticking close to parents.* **(Session 1: in person)**

An engrossing quality transferred into the clinical session

> *Sitting on his mother's knee, Archie turns his body to see a box of toys and excitedly says something unclear. Mum comments that he has noticed the cars and he gets down from his mother's knee and begins to explore the box. Everyone is engaged in watching him. We are all engrossed…He pulls out the police van, then a white and red car. He seems to be naming these but he has his back to me and his speech is unclear. Mum appears in tune with his words and repeats what he says. There is a sense of mirroring between Mum and*

> *Archie. She appears to echo his speech rather than have a conversation with him…. I again notice how engrossed we all have become in watching this activity and make a comment about wondering if Mummy is often Archie's helper? Mum comments that she is in a humorous tone and neither parent seemed exasperated at this.* **(Session 1: in person)**

Archie's ability to draw us and his parents into his world continued throughout the intervention

> *Conversation between the adults would pause as Archie announced and held up each of his toys to show us. I am reminded how captivating he can be, creating a situation in which all four adults are drawn to him.* **(Session 3: online)**

> *Mum shouts out…"There's a towel on the side to wipe your hands Archie". I comment on how Mum is intuitive in her response to Archie…Mum laughs and says, "Oh no, am I doing it without even knowing?" …I say that she is in tune and noticing what he wants without him needing to verbalise that to her.* **(Session 4: online)**

Archie's referral form detailed an experience of a child who had many fears and was scared in some of his interactions with the external world. It was therefore no surprise that themes of danger and safety were present within observations of Archie's play from the first session

> *Archie comments on the crocodile's teeth "snap, snap", he says. …He pulls out fence pieces and begins to arrange them into a square. He and mum talk about the fence and keeping the crocodile "safe". Mum wonders, "Is that to stop the crocodile biting?" Archie places the crocodile in the fenced area and stands up looking around as if to show that it is now safe. There is a confused feeling of Archie implying that he has made the crocodile safe. I wonder about the meaning of this safety – is the crocodile safe from the room, from us? Is he, or we, safe from the crocodile? Is the crocodile safe from Archie's own aggression?*

> *Archie again gains our attention by knocking over the fence and letting the crocodile break out. He asks, "Is there is a roof?" but he remains sitting. My colleague reaches to offer Archie a piece of paper as I wonder out loud whether Archie might find a roof? I wonder about the wish Archie elicits in others to help him. Archie says "paper" while continuing to sit back on his bottom with his leg underneath him. Dad encourages Archie to look and see if there is any paper. Archie notices the paper on the table and gets up, rebuilds the fences and puts the crocodile back. He places the paper onto the top of the fences. He then gets low to the ground exclaiming something unclear. We all wonder about the crocodile being safe again? ......Archie then returns to the floor and he quickly breaks out the crocodile from the paper roof. Everyone is captivated by this play again and whether the crocodile can be contained. Archie's attempts appear elaborate but ineffectual. I wonder about it being safe to continue chatting with Mummy and Daddy? I am aware that the need for safety has got into projected into everyone.* **(Session 1: in person)**

The link to danger and the need to re-instate safety were present not only in the discussions of Archie's day to day fears of leaving the family home, but also linked to the parents account of the pregnancy and Archie's birth. Archie's mother had experienced illness during the pregnancy followed by the alarming breaking of her waters at twenty weeks. A long labour required emergency medical intervention immediately following his birth. After being at home for a couple of days, there was a parental worry regarding his physical health but the hospital staff reassured them and they returned home again. Archie had difficulty feeding from birth. He couldn't latch on, was tongue tied and experienced reflux.

When thinking about the experience of Archie's birth with the family, he was observed to build a fire engine, as though he had an awareness of the mechanisms that could re-instate safety within a situation of danger. Archie was also observed to lie across his mother's knee, as if he were sensitively aware of the concern and anxiety that the account of his precarious start in life may have provoked.

Archie’s concern about potential dangerousness, embodied within clinical sessions through his play with the crocodile, continued into the second session which was also attended by Archie’s two year-old brother, Daniel

> *On entering the room, Archie goes straight for the toy box and retrieves the crocodile…. he takes the crocodile to mum’s breast and says “roar”. Archie brings the rugby ball to the table. He says “Mum” but his mother doesn’t reply. Dad says, “Yes? Archie”. Archie doesn’t reply. He throws the ball lightly at the crocodile on the table and moves away. Archie now has the crocodile on the floor and is gathering the fences to build together. He comes to the table and takes a piece of paper…Dad comments that Archie had asked if the crocodile would be here again today. I say that the crocodile has been in his mind since the last session.* **(Session 2: in person)**

However, in this session the presence of Archie’s young brother brought with him an ability in Archie to move away a little from his thoughts regarding themes of danger and safety

> *The crocodile again needs to be contained by Archie and he is building a fence shape which he holds aloft “a ring”. He builds and re-builds the ring and the crocodile is left lying on the table. Daniel has interjected in the play…and he has now picked up the crocodile and is looking at its’ teeth and how the jaw moves, yet there is a great sense of fun about his play in comparison to Archie’s. Archie is watchful of this play. Daniel shows the crocodile to Dad and to Archie and there is a sense of joy rather than trepidation in this. Daniel introduces an idea of giving the crocodile some milk in a cup and he attempts to do this…Archie continues with the ‘ring’ building and then places the cup of milk in the enclosure with the crocodile. Daniel says something about the crocodile being hungry. I wonder what the crocodile might eat? “Birthday cake!....babies!” is the reply from Daniel… Archie comes around with the baby doll from the box and Daniel has the crocodile. He laughs as he shows the crocodile biting at the baby. Daniel says that the crocodile needs a poo and both boys laugh.* **(Session 2: in person)**

Despite the length of time between the second and third clinical sessions due to the shift from in person session to online, Archie continued to refer to the crocodile

> *I acknowledged how Archie was showing us his toys at home on this occasion, rather than the toys we had when he visited the clinic, such as the tea set and the animals. Archie said, "the crocodile". I said, "Yes, we had thought lots about how Archie played with the crocodile before, that today he is showing us toys that transform into something else, a bit like how we had transformed to being on his computer screen today.* **(Session 3: online)**

> *Mum enters the room and we say hello. I say something about seeing us on the computer screen again and not at the clinic…Mum says that Archie had been talking about the crocodile at the clinic. I comment that I am in the room where Archie was ensuring the crocodile was kept safe. Mum said that Archie had said that he was, "…protecting mummy from the crocodile". Archie's mother said she wondered 'what he was protecting mummy from?' Archie said, "He wanted to eat Mummy!" I think of Archie's own greed and wish to devour his mother and the need for such feelings to be constrained against.* **(Session 6: online)**

The humanising of the crocodile that eats and defecates within the second clinical session led to Archie's parents commenting for the first time during the intervention about Archie's own toileting issues as raised within the referral.

> *The parents talk about Archie's toileting…they started toilet training twelve months ago but six months later there were daily accidents…. Dad says, "Archie doesn't seem to want to recognise the need to use the toilet. He will dance around and we'll encourage him to go but he will refuse. He's had accidents" ….Archie comes over, leans across his mother's knee and looks directly at me.*
> **(Session 2: in person)**

The clinical sessions became a vehicle for thinking about Archie's toileting with him

> *I wonder how Archie knows that he needs the toilet. "My body tells me," he replies…" sometimes I hold it in my tummy...it's ok, I like it when it comes back into my tummy, into my head and comes out of my mouth!" and he gestures by opening his mouth really wide and sticking out his tongue. Mum exclaims "No! ". Dad says, "Was that a joke?" I wonder about Archie liking the feeling of not letting his poo go sometimes and liking the feeling of keeping it right inside his body. He tells me he holds his poo in at school too. Archie then turns to his father and says, "Do you have a poo?" and to his brother he says, "Do you have a poo?* **(Session 6: online)**

Over the course of the intervention, clinical observation of Archie enabled recognition of his developing agency to be noticed. Within the first session, Archie had appeared younger, scared and dependent. The attendance of his younger brother into the second session enabled a more grown up, playful version of Archie to be considered. Within his play, he moved from aspects of danger to a role play of family life placing himself in the role of the father. By the third session, a more confident Archie was evident online

> *As Archie moves in front of the computer screen to out of sight, he gestures with his hand and says, "Back in minute!". We all laugh and I comment that Archie is letting us know he is busy building his Lego but will be back to show us soon. Archie repeats this gesture several times as he moves in and out of the screen during the session. I notice the increase in his confidence in communicating with us in this quite grown-up way.* **(Session 3: online)**

> *Archie walks into the room quite confidently, positions himself behind Mum and Dad's chairs and sits on a sofa at the back of the room. He is eating a rice cake…Archie moves and now stands near the computer screen. He shows us his T-Shirt – superheroes in sequins. He shows us how the sequins move up and down to reveal another picture. Archie says he wants to show us his toys. He holds up 'Medic' – a robot transforming to an ambulance.* **(Session 4: online)**

> *Dad spoke of playing 'the fool' when Archie was putting on his school uniform (on the first day of school) so that Archie could then be all knowing, explaining to Dad how it is done and getting himself dressed in his uniform. We think about Dad taking on Archie's confusion and enabling Archie to then feel more confident.* **(Session 5: online)**

> *Archie's parents said they had noticed him become confident with his speech and also around new people. They described Archie wanting to ask questions to someone new or show his toy. He had also asked about when he would be seeing (the Child Psychotherapists) to show his new toys to'…. Mum asks about the letters Archie has learnt. Archie says "A" is his favourite because it's the beginning of his name.* **(Session 6: online)**

> *Archie begins to giggle and lift his T-shirt three times showing his torso. It is hard not to be amused by his growing confidence. His parents seem a little embarrassed and his mother tries to talk with Archie about what they have done this week. Archie replies "walking" and they "jumped in puddles". Archie puts his hand up his top so that his hand comes out of the neck, and he wriggles his fingers and laughs. He then begins to stick out his tongue and the parents tell him not to. He stops and turns away from the screen and I comment on this more confident, a little bit cheeky, Archie that we are seeing today.* **(Session 6: online)**

> *Mum explains that they also went to visit grandma and grandad. I wonder about these journeys in the car and how it went? Mum says, "It was ok" a little hesitantly. Archie says something about "driving fast". Mum says, "Archie likes going superfast on the motorway. What else do we do in the car?" "Seatbelts" he answered and I'm reminded again of his need to restore safety to the idea of the 'superfast' motorway.* **(Session 6: online)**

Archie had also begun to make some progress regarding his toileting by his parents being supported to utilise his growing ego strength and wish to be independent

> *Mum says that Archie had been taking himself to the toilet, taking his nappy off and having a poo.* **(Session 8: online)**

Within the intervention, I considered how Archie had developed certain rigidities around transitions, sleeping and eating to help manage his anxieties. Such ways of ordering his environment enabled Archie to provide a predictable and controlled approach as a means of reducing any anxiety that might be provoked by uncertainty.

Within the eight sessions during the intervention, Archie's parents had reported seeing gradual improvements in Archie's levels of anxiety and his ability to manage this. Although Archie continued to require additional support at times to help him to manage his anxiety, his parents reported an observed easing of his worry about leaving the family home, communicating with others outside his immediate family and he began to show less distress in situations which previously caused him great alarm.

Feedback from his parents and schoolteacher was received regarding his successful transition into primary school during the course of the intervention. He rarely verbalised negative comments about school and he was able to get himself dressed and be ready for his school day. Once at school, Archie was described as keen to learn. He was also supported to use the school toilets by his teacher. Teaching staff felt that Archie could thrive within mainstream education without the need for additional support.

Following the completion of the clinical intervention, Archie continued to display some difficulties in relation to his anxieties and toileting. It was agreed that he would be offered a child psychotherapy State of Mind assessment with a child psychotherapy colleague to further understand this. Archie shared his worries about using the toilet and his anxiety about needing to contain 'messy' feelings were observed. Follow up liaison with Archie's school and school nurse was also a feature of the work that continued.

4.2 Case Study Two – 'Bonnie'

Bonnie was four years old when she was referred to the brief parent-child intervention. She was White British and lived with her parents and three older siblings. Bonnie and her parents attended seven clinical sessions which focused upon parental concerns about her anxieties and behaviours, within a context of attachment difficulties as identified by her Paediatrician. A range of paediatric interventions including occupational therapy, speech and language support and behavioural interventions had been provided to Bonnie and her parents since the age of eighteen months.

Prior to Bonnie's birth, her mother had experienced post-natal depression following the birth of Bonnie's elder sister who had physical health difficulties requiring an organ transplant. Although Bonnie's mother continued to experience depressive episodes, she informed me that she did not want to seek support from her GP as she did not feel confident she could receive support that could help her. There was also a history of significant sibling rivalry which at times had led to Bonnie's elder brother being physical aggressive to their mother, as well as Bonnie's elder sister positioning herself as their mother's protector. There was an absence of a sense of Bonnie's father observing and responding to both his wife's depression and the domestic abuse happening in the family. Although Bonnie's father attended sessions, he was often quiet and relied on his wife to provide a narrative. Observing a lack of confidence in his ability to contribute, efforts were made to encourage his views to be expressed which often provided a helpful, and sometimes contrary, account to Bonnie's mother. Through the work, I was also able to consider the longer-term impact that the parents own trauma experience of being parented, which had included the use of physical chastisement and a lack of emotional warmth at times, could impact upon their parenting of Bonnie.

Bonnie attended her first session in the clinic with her parents. First impressions were of a child wishing to appear confident and independent

> *Bonnie's parents are sitting with an empty chair between them…I say Bonnie's name but simultaneously verbalise that she does not appear to be there. Dad indicates that Bonnie is behind us. There is a small girl with blonde hair pulled back in a ponytail wearing a pink puffa style coat, t-shirt and pink leggings with unicorns and rainbows on, a red bead necklace and pink shoes without socks. She walks back to her parents behind us carrying a plastic glass of water.* **(Session 1: in person)**

This confidence was also evident in Bonnie's play as she wished to assert her independence and authority, possibly giving her parents a feeling of being redundant, or wishing to show them her more able side

> *Bonnie then goes back to the giraffe. The leg has come off. Bonnie tries a couple of times to push it back in but cannot. Mum offers to help but Bonnie says, "No". I think to myself that Bonnie does not want to accept help. Mum then suggests Bonnie takes her coat off. Bonnie replies, "No" but then discards the coat onto the floor behind her. Mum turns to Dad and repeats Bonnie's answer and then action. Something seems humorous but also maybe humiliating for Bonnie's mother.* **(Session 1: in person)**

> *Bonnie goes into her mother's bag without permission and gets out an inhaler. She tries to fit it together but can't get it to. Dad intervenes to try to help but Bonnie won't accept help again. Bonnie tries to use the inhaler as it is. Mum calls across to Bonnie that she needs to shake it before using. Bonnie abandons the inhaler.* **(Session 1: in person)**

> *I comment that it seems like Bonnie would like to be like a big grown up. Bonnie nods her head then climbs to Dad's shoulder and stretches up her arm to the ceiling. I copy this movement showing how big she wants to be, wanting to be the tallest here. She grins and tips her head back with excitement at this. I go on to say that it can be hard to be small and let Mummy and Daddy be big. "No!" she says. Mum comments, "Bonnie thinks that she's the boss in the family". Dad then asks Bonnie, "Who is the boss?" and Bonnie shouts, "Me!"* **(Session 1: in person)**

We also quickly observed fragility in Bonnie as she used a dummy at times during the sessions, as well as placing her hand down her mother's top and squeezing her breast, following a discussion about Bonnie attending school

> *Bonnie comes over to her Mum and puts her hand down her mother's top to grab at mother's breast. Neither parent commented. Bonnie then moved away. I comment on this and Mum says, "She does it all the time…it didn't start straight after stopping breastfeeding.* **(Session 1: in person)**

Over the intervention we observed and heard about how Bonnie used a range of oral soothing methods to help manage her emotions. She achieved this by exploring her world in a bodily way through her mouth by licking and chewing. She had also been observed to use self soothing masturbatory types of behaviour - rubbing her groin against the floor, as well the oral soothing of placing either a dummy or her fingers in her mouth.

> *Bonnie gets the teapot and begins to pour out drinks – tea for Mum and then tea for Dad. Dad however rejects the teacup saying, "No thanks, I don't drink tea". Bonnie looks rejected and I feel her frustration at a Dad that seems to not want to connect in this moment of the game. I wonder out loud what Dad might drink? "Coke", he replies and I feel as if there is another child in the room, one who doesn't get quite what they want. Bonnie then moves to the telephone and begins to dial and asks Dad for his telephone number. "999" he replies. Bonnie presses the numbers and Dad answers the call by saying "Police". Bonnie protests and again wants Dad to give her his telephone number. I comment that Bonnie wants to make a call to Daddy, to speak with Daddy. She drops the phone and returns to running around the room…Bonnie comes near to my feet and lies on her back and then her front and begins to rhythmically raise and lower her legs, rubbing her genital area on the floor.* **(Session 3: in person)**

Over the course of the intervention, Bonnie's parents spoke of how the various interventions and strategies they had been offered to support Bonnie had in fact left them feeling confused and de-skilled in their abilities

> *Mum retells a story of Bonnie demanding food at 9pm by trying to open the fridge and mum holding the fridge door closed. Bonnie responded by shouting and screaming at Mum. Mum shouted "no" back to Bonnie. Mum says, "I need to*

> *‘follow through’ as though she recognises how ineffective she has become.* **(Session 2: in person)**
>
> *Mum begins to talk about the sessions she had with a Paediatric clinician and says, “He says, because my words aren’t good enough, that I should give Bonnie two choices when I want her to do something so that she feels in control”. I listen and then say that I’m interested in what she said at about her ‘words not being good enough’. She says, “I don’t feel I know what to do or say anymore”. Dad agrees. I think of the many professionals, reports and advice they have received and comment on this, that maybe it feels that they have lots and lots of advice, that somewhere maybe they have lost trust in themselves to know what to do. Mum agrees and says, “Some of the advice helped for a bit and then stopped helping”. Bonnie is now lying face down on the floor behind Mum and Dad’s chairs continuing to rub her genital area on the floor. Mum comments, “We just ignore this behaviour now”.* **(Session 3: in person)**

We thought about how Bonnie often wished to assume a parental, pseudo-adult role and how this had been met with humour from her parents and family members, which had in a way created a sense in Bonnie that this behaviour was encouraged or permitted in some way. However, within sessions, we thought about how this behaviour can also feel rivalrous in relation to what the parents were trying to achieve. A key part of the brief intervention was to think with Bonnie’s parents about how her assumed sense of power could also feel overwhelming at times, and that over time Bonnie may experience a sense of relief knowing that she had robust parents present to curtail any brief attempt to inhabit the parental role. A vital part of the work was to provide an alternative approach to parental thinking that all of the difficulties were located in Bonnie, and for them to consider the role they positioned themselves in also.

I observed how these behaviours and the parents feeling of ineffectiveness continued as the intervention progressed with online sessions. There were also opportunities to observe Bonnie placing herself in an infant role, as she appeared to oscillate between the infant and pseudo-adult states of mind

> *Bonnie's Mum spoke of her wish not to upset or make Bonnie cry (when putting Bonnie to bed and the elder siblings still being up) and we thought about how that was impacting on parents' ability to implement a night-time routine…. Bonnie returned to the screen wearing no top and sucking a dummy. I observed how there is a baby part of Bonnie that continues to be very present still and how it might be hard to share Mummy with her brothers and sisters. Bonnie said, "Mummy is only MY mummy" and she grabbed at Mum's breast and lay across Mum's knee sucking her dummy.* **(Session 7: online)**

Bonnie was also observed to make progress in a few areas over the course of the clinical intervention. She became more engaged with the psychotherapists and a wish to show a more able side of her who could draw, read and write with some improvement, as well as beginning to accept her mother's support to do so

> *When Mum asked Bonnie questions about what she had done at school, Bonnie did not answer and dismissed Mum, however when I enquired about this, Bonnie went to get her book bag to show me her book. Bonnie read to us and appeared focused and spelt out letters phonetically such as 'pen'. She showed mild frustration at difficult words by making a crying noise, however Mum supported her through the reading and praised her.* **(Session 6: online)**

During the intervention, we were also able to consider at a generational level how such role reversals can be re-created

> *I think of the muddled roles again. I comment that Mum became the helper for her Mum. Mum says, "With somethings my mum needed more help than we did". Mum says, "I was more like a friend for her" …as we think about Mum's relationship with her mother, Dad interjects and says, "Gran shouts a lot". Mum looks at Dad and then concedes, "Yes, she does". Dad then says, "You shout a lot too". Mum laughs but in agreement. Mum turns to us and as if admitting this says, "Yeah, I shout a lot too". Dad says, "You shout when the kids aren't even doing anything". Mum again agrees. Her eyes fill up and she looks like she might cry. I acknowledge how we have all been parented in different ways, that they*

> *have lived in families where you might need to shout to be heard or to keep quiet in the hope that no one notices you. Dad nods and smiles to the latter.* **(Session 3: in person)**

Although some progress was evident in Bonnie's behaviour and her parents' response to this, such inter-generational difficulties require a longer-term intervention than the brief parent-child psychotherapy intervention could provide. Bonnie's family were keen to engage in longer term individual work for Bonnie, supported by parent work that could continue to support them to respond to Bonnie beyond the remit of the brief clinician intervention.

Bonnie's difficulties were understood in the context of a complex family history where difficulties continued to be experienced in relation to her mother's history of depression and strained sibling relationships due to competing individual needs for parental support and guidance. Following the completion of the brief intervention sessions, Bonnie's parents agreed to her participating in an assessment for weekly child psychotherapy with a child psychotherapy colleague. I offered parent sessions in parallel. A recommendation for intensive child psychotherapy was not able to be supported by her parents and she continued to receive weekly psychotherapy, alongside regular parent sessions, to help further consistent support to be provided. Bonnie continued to use the sessions to move between regressed behaviours and omnipotent feelings to support her to be more increasingly able to tolerate her more age appropriate development. Bonnie's parents continued to be supported to feel more effectual and consistent in their parenting, however the wish to seek a neuro-developmental diagnosis continued to be evident for her mother in particular. This was understood in the context of the mother's resistance in considering the attachment difficulties.

4.3 Case Study Three – 'Carl'

Carl was four years old when he was referred to the brief parent-child psychotherapy intervention. He lived with his parents and elder half-brother, Edward. He was White British-European. Carl had been referred to the brief child psychotherapy intervention after receiving support from paediatrics in the form of speech and language sessions, occupational therapy support and specialist behavioural support provided to his mother. Carl had received a social communication assessment by Paediatrics and had been diagnosed with a Sensory Processing Disorder and delay in his receptive and expressive language. Parental and nursery school concerns continued due to Carl's aggressive behaviours and mimicking of animals. Carl and his mother attended five sessions, which focused on parental support to alleviate Carl's aggression in relation to frustration, separation anxiety, emotional developmental delay and mimicking behaviours.

Carl attended his first session in the clinic with his mother. First impressions were of a child who was developmentally younger than his age. His mother communicated with him in a very close, direct manner

> *Carl is standing near a toddler activity table. He moves the flaps that make a noise and the lights flash. He is wearing a walking harness around his torso but it does not have the part which his mother would hold. He seems tall and I am reminded of an overgrown baby. Carl smiles and looks at me as I say his name…. Mum says to Carl, "Look at me" and she looks directly at him, coming very close to his face. Mum then signals with her hands whilst saying, "Time to go" as she moves to follow to the room.* **(Session 1: in person)**

Carl's use of aggression to manage frustration became quickly evident in the first clinical session when he felt that his need to leave the session was not met

> *Carl is now standing on the chair again next to mum. He is looking at the clock and says, "want to go home" although the session has not finished. I comment that Carl is wondering about whether it's time to go home yet…Carl has picked up the toy telephone again. He lets the phone receiver dangle from the cord. He then stamps on the phone with his foot. His mother firmly says, "No, it will break and need to go in the bin". Carl steps off the receiver and moves to the fire engine. His mother says, "good"….He then comes back to me placing the fire engine on my head pressing it down a little strongly. He then moves to place the*

> *fire engine on my colleague’s head too, then the table and then the windowsill. His mother comments that this is what Carl does at the nursery but the children aren’t as accommodating as adults.* **(Session 1: in person)**

Carl’s potentially aggressive feelings perhaps also suggested a fear of the loss of connection with his mother whilst she spoke to the psychotherapists. Further observations of Carl as the session progressed appeared to indicate this

> *As I speak with his mother, Carl circles me in the chair holding a crocodile. When he is directly behind me, he says “Where’d it go?” I play along wondering out loud where the crocodile went, where Carl went? Carl hides under my chair and says, “Where are you?” then crawls out and returns to be near mum…Carl says, “sharp teeth” and he uses the crocodile to bite at his mother’s finger. Mum says, “Make it better” and Carl kisses her finger…Carl climbs onto the empty chair next to his mother. He stands tall. Mum seems very vigilant to this as Carl leans forward and falls onto his mother. He gets back up on the chair and repeats this two more times…. Carl returns to the doll’s house and picks up a chair from the house. He appears as if he is going to throw the chair and his mother flinches and says, “Please don’t throw” but Carl has already moved to drop the chair.* **(Session 1: in person)**

As the clinical sessions continued with Carl and his mother, a picture developed of a dyadic relationship in which Carl’s fathers’ physical absence through his long hours of employment, was the cause of some frustration and aggression for Carl. In the second session, Carl was observed drawing pictures of his family members on a white board

> *Carl then says, “Rub away now” and he picks up the wiper and rubs the drawing of Carl away.” Where’s Carl gone?” Mum says and I’m reminded of a Peepo game. This continues until Carl’s mother says, “Where is Dad?…and turning to Carl says again “Where is Daddy at?” Carl looks at the floor but doesn’t speak so his mother finishes this and says, “Work”…saying Carl has got a bit better when he comes home now, that he used to hug his father and almost “smother” him but now he gives his Dad time to shower and get dressed….I begin to talk*

> *about the feelings Carl might have about missing his Dad but then also feeling like he might want to 'smother' him when he's returns, like when a child is lost and the parent feels cross and happy when they are found. Mum nods saying, "Maybe this is how Carl feels". Carl has moved away from the screen but can still be heard playing with something. An object flies across the room…. I wonder what it was that Carl had thrown. She holds up a figure of a small orange man explaining it's from the game 'Frustration', a game Carl plays with Dad. We link Carl throwing the object when hearing us talking about Dad…Mum says, "I wouldn't have thought about it in that way but now it's been explained like that, it makes sense. I say that Mum maybe must bear the feelings that Carl has about Dad not being there. Mum agrees.* **(Session 2: online)**

During the remaining sessions which all took place online, Carl's mother re-counted information about Carl's response to this father's absence

> *Carl's mother said it had been helpful to talk to Carl's father last week about the session and beginning to link Carl's emotions and behaviour as she and Dad had never linked it in that way before…. Mum said, "We can also use 'cross'" as she spoke about the words for feelings she has been teaching Carl. She gave an example of Carl urinating on her bedroom floor…She says, "In the mornings, Carl would come into our bedroom and say 'oh, oh', take his nappy off and wee on Dad's side of the bedroom floor".* **(Session 3: online)**

As the sessions progressed, we were able to consider the relationship between Carl and his father and how in turn she could develop his father's understanding of Carl as her own increased,

> *Carl's mother described Carl's father as finding Carl "too much" and she felt he "didn't understand Carl". She said that Carl tended to hit his father more than her. Dad and Carl often had play fights but Carl's father didn't understand that Carl couldn't differentiate when the play had ended and Dad would get annoyed when Carl hit him.* **(Session 4: online)**

Carl’s progression throughout the clinical sessions was heavily influenced by his mother’s willingness and ability to scaffold and support him. Small improvements were noted in Carl’s ability to withstand the frustration of participating in more triadic communication

> *I say to Carl’s mother that I’m mindful that she needs to move her attention between Carl and the psychotherapists on the screen. Carl’s mother replied, “Carl is getting a little better at waiting”. She says, “I say ‘waiting’ to Carl and now he is able to wait for short periods, like when I’m talking to his Dad, he is able to do this a little…. sometimes he can’t and he doesn’t really understand how long he has to wait for but he is able to wait a little more”. I comment on how Carl is progressing with her support.* **(Session 2: online)**

Carl’s interactions with his mother and her growing understanding of how to meet his needs and adapt his world to reduce his frustrations brought with it a difficulty for Carl in experiencing triadic relationships and he struggled to share his mother’s attention with another. Towards the end of the second appointment, Carl demonstrated how hard it was for him to bear the intrusion of a third object into his relationship with his mother

> *Carl is then heard saying “ball” and his mother’s attention is turned back to him. He comes near his mother and moves the place where she sits by physically holding her to move her…As they begin to pass the ball, Carl interjects saying “Not one hand!” and his mother begins to explain that Carl wants her to use two hands to play but she is holding the screen too. She begins to say, “I’m holding the screen to speak with [names the psychotherapists]”. Carl comes to her and tries to take the screen out of her hand but she holds it further away. He goes off screen and is heard crying. I think of his mother literally single-handedly parenting.* **(Session 2: online)**

In the fourth online session, through the continued support of his mother, Carl was more able to bear the intrusion of the psychotherapists on the screen observing his play

> *Carl came to the screen and sat in front of us. We waved and Carl's mother said, "Who is that? [names the psychotherapists]" Carl replied "Yeah" and went back to his mother who was now taking out some dinosaurs from a box...Carl looked at us, then back at his mother who was now taking out figures from the box…Carl's mother said, "That's mine…I'm helping you". Carl and his mother then proceeded to place building bricks in a row around a green board. Carl said, "You're helping me".* **(Session 4: online)**

As the session progressed, Carl appeared to tolerate our online presence more easily

> *Carl stood to walk back and fell lightly on the floor and lay there near the screen…Carl said, "Boy flying" and lifted his figure up high while continuing to look at us on the screen….Carl moved off the sofa, closer to his mother and reached out his figure. Instead of throwing the figure, he placed it near his mother's cupped hands. His mother raised her hands to clasp the figure from Carl. Carl then came and sat in front of us on the screen again, a bit longer than previous times, looking at us and the toys near him.* **(Session 4: online)**

Within the first clinical session, we thought about Carl's use of mimicking scary and loud animals when he identified with their aggression as a means of managing his more vulnerable feelings. Carl's wish to assert a more robust version of himself through the use of animal mimicking was briefly seen in the first session when we thought about his development as a baby

> *Carl then comes to me. He stands very close to my left side, staring at me as he continues to hold the crocodile. He moves the crocodile to bite my arm. He then stands behind me again. I turn left and right to see behind me. Carl moves the opposite way each time I turn and I say that Carl is wanting to stay hidden from me. He then gets onto the floor behind my chair and gives a roar saying, "I'm a dinosaur". I link back to thinking about Carl as a baby, that maybe Carl has been listening to his Mum talk about Carl as a baby. Carl says, "Not baby…BIG!' I*

> *say that Carl is reminding us that he is a big boy Carl now.* **(Session 1: in person)**

Stepping into the role of a dinosaur provided Carl with an experience of imaginatively taking up a more confident, omnipotent role. During the clinical intervention, Carl's mother observed that these behaviours ceased and within clinical sessions this behaviour was not observed. During the final session, Carl's mother reported that he had begun to mimic animals again but this was less about his wish to appear scary and frighten others away. He now mimicked how a dinosaur walked with stomping feet and holding his arms like a T-Rex. The emphasis now was on imagining himself to be stronger and more solid.

Over the course of the clinical intervention, Carl progressed in his communication with others and was observed to be lively and engaged when communicating directly with another and feeling held by their attention. He began to demonstrate a wish to connect with others and his mother supported him to achieve this.

Carl was discharged from the intervention following the completion of five sessions in line with the Tavistock under-fives model. He had been referred back to the Paediatric service by his school for a further neuro-developmental assessment for autism.

4.4 Discussion

A number of shared features across the intervention cohort were evident. All the referred children had received a foundation of support from universal and paediatric services prior to their referral to the brief intervention. All three children and their parents had engaged with paediatric diagnostic assessments and clinical interventions which included occupational therapy, speech and language interventions and paediatric assessments. Prior to this, the children had been supported by their Health Visitors or GPs. Despite this level of health support, the children continued to present with emotional and behavioural difficulties beyond what their parents could support. Through provision of the brief intervention, each of the parents to varying degrees were able to consider the child's difficulties as a communication, alongside thinking about the child-parent relationship, as well as the wider family dynamics and generational aspects of parenting.

This feature of something feeling stuck, which often had become located within the child’s behaviours, in turn may have characterised the context in which parents engaged with the offer of a brief parent-child intervention. Parent engagement and a willingness to try and understand and respond to their children’s emotional development was evident across the intervention cohort. In particular, Archie and Carl who could be considered ‘at risk’ of autistic traits (Rhode: 2016) would benefit from a joint paediatric child psychotherapy intervention to work with parents where a negative cycle of communication could evolve. All the parents were prepared to reflect on their own experience of being parented and how they responded to their child. In turn, they were willing to reflect on the role that their child may be placing them in, as well as the role that they themselves assumed for the child. A lack of confidence in the parent’s ability to help and understand their child’s behaviour was evident. Clinical work to promote the role of the parent was a substantial part of the intervention that was undertaken.

Parental engagement was key to the child making positive progress during the brief intervention. It is through harnessing the parent’s ability to promote a relationship with their child that is both age appropriate and supports the child to explore their world in a safe and enjoyable way, that changes can be apparent. All the parent’s demonstrated a commitment to the intervention. They were prepared to continue the brief intervention online when required. This was new territory for all involved. Active parental facilitation of the intervention in Carl’s case became central to the therapeutic work as he experienced the greatest difficulties in accepting a triadic relationship. Related to this transition to clinical work at a distance was the need to extend the number of sessions of the intervention. This was in part due to the shift and a limit to what could be realistically achieved in each session whilst there were competing distractions. Other factors which impacted were due to the frequency of the sessions offered as sometimes this needed to be lengthened either due to illness, holidays, or the children returning to school, resulting in longer gaps between sessions that had been planned.

One aspect of the clinical intervention that I had not considered would be the desire in parents to continue to receive support after five appointments had been offered, as per the original design of the study. In line with the Tavistock clinical model, up to a further five sessions could be offered. The impact of transferring to online work during the intervention partly contributed to this as there was a sense that in-person sessions may resume at some future point. The drive for shorter term targeted clinical interventions within the NHS is increasingly prevalent, and it can be a challenge for child psychotherapy to be seen as providing a viable short-term intervention due to the often wrongly characterised nature of being perceived to only offer longer term individual work with a child. However, even the provision of a five-session model within the commissioning of some services would not be possible. The paediatric service within this study provided a three-session model to assess the needs of these children. With this in mind, the under-fives intervention model was evidence that the provision of a time limited, rather than 'short-term' intervention, that improves a parent's ability to understand and support their child's emotional wellbeing and behaviour was entirely feasible, such as in the case of Archie and Carl. Even when work did continue, such as in the case of Archie, it was not necessarily longer-term work that was required. In cases of complexity, such as in Bonnie's circumstances, the brief model acted more as an extended assessment and provided a foundation for more longer-term work.

Some differences across the intervention cohort were also apparent. The engagement of fathers differed. In Archie and Bonnie's cases, both fathers attended and contributed during the in-person sessions. This became more difficult as the intervention progressed online either due to work commitments, or a lack of engagement when the sessions transitioned to being at home. In particular, Bonnie's father attended and contributed to in-person sessions but subsequently placed himself on the edge during the online work. Requests for his presence were made as when he did attend, his insight and contribution was often very helpful in supporting, as well as gently challenging Bonnie's mother. Carl's father was not present during any of the clinical sessions, despite best efforts to try and encourage this also. It was no surprise therefore when themes of his father's absence and his mother's need to often manage alone came into the clinical work with Carl.

The degree to which the parents had positively perceived the support they had already received from universal, paediatric and school services may also have been an indicator as to how open they were to consider a psychoanalytic perspective on the difficulties experienced. Archie and Carl's parents often voiced positive experiences of the support they had received prior to the intervention, and as the intervention progressed, they continued to build on the interventions and strategies they had already received from other professions. In comparison, Bonnie's parents expressed feeling let down by services and at times they felt they were not believed in the difficulties they experienced at home. This may have impacted on their view of what, if anything, could be helpful. All the children had experienced transitions to primary school that had been impacted upon by the COVID-19 pandemic. The ease of transitions therefore varied and appeared to be smoother where the parents had an experience of feeling they were listened to and not judged.

The referrals also differed in their suitability for a brief intervention. The amount of professional support that had already been provided to Bonnie from universal and paediatric services may have been an indicator of the difficulties being beyond the remit of a brief intervention. However, despite this, all the parents observed some positive changes during the intervention.

The next chapter will outline the findings from the research study.

5 Findings

The aim of this research study was to consider what contribution a brief parent-child psychotherapy intervention could have upon the community paediatric clinician's diagnostic assessment of children aged under-five. My hopes for the study were to provide a clinical intervention that families felt was beneficial, and community paediatric colleagues would find valuable as a contribution to their assessment of the referred child. I aimed to find out if this was how the clinical intervention was experienced through a mixture of standardised outcome measures collected from the parents of the referred child, alongside semi-structured interviews with the referring paediatric clinician.

I was aware of the possible clinical effectiveness of the intervention through my review of the literature about this clinical model. However, I was unsure whether the referred children and their parents would experience the intervention in the same positive manner, although this was not the main purpose of the research. As detailed in the Literature Review chapter, there were no previous studies regarding referring clinician's views of a brief parent-child psychoanalytic psychotherapy intervention. I was therefore unsure how the intervention may be received, and whether the referring clinicians would value the intervention within their own diagnostic assessment. There was a greater level of uncertainty present as the locality in which the intervention was finally offered was not the locality in which the initial idea for this research study originated. In essence, the research study also needed to consider the provision of a brief intervention for under-fives in a locality that had not had prior experience of the intervention.

In Part A, the findings of the research will be presented as data taken from the standardised outcome measures completed by the referred child's parent at the start and end of the brief parent-child intervention. In Part B, themes from the research findings from the semi-structured interviews with the referring community paediatric clinicians will then be presented as extracts of data from the semi-structured interviews.

5.1 Part A: Findings from the brief parent-child intervention

The use of standardised outcome measures have become common-place in NHS mental health services for children and young people. They are important tools to monitor and evaluate services and a range of standardised outcome measures can be applied in clinical settings. As this was a study aimed at considering an area of service development the contribution a brief intervention could make to the paediatric assessment of young children, practice-based evidence using routine outcome measures were included within this study. Standardised outcome measure questionnaires were completed by all the children's parents at the start and end of the brief parent-child intervention. The results of this data were included within the referred child's Clinical Formulation report so that the referring clinician and child's GP were informed of the parent's perceived improvements in the child over the course of the intervention.

Two forms of standardised routine outcome measures were completed by all parents which I will now present.

Goals Based Outcomes

Goal Based Outcomes (GBO) are "a way to evaluate progress towards goals in clinical work with children, young people, and their families and carers. They simply compare how far a young person feels they have moved towards reaching a goal they set at the beginning of an intervention." (Law & Jacob: 2013: 10). They are useful as a tool within clinical work as they promote collaboration with a young person or parent in establishing the nature of the clinical intervention being undertaken.

Within the clinical intervention, the rationale for using the GBO measure was that it was thought it would be helpful to consider what goals the parent had regarding the brief intervention that was being offered and how this may have agreed with or diverged from the referring community paediatric clinician.

Parents were asked at the start of the intervention to identify up to three goals that they would like to work towards during the brief parent-child intervention. This enabled the researcher to find out what concerns the parents held and if these were in tune with the referring clinician. Parents were asked to score on a scale of 0-10 how close to reaching their identified goal they were at the start of the intervention and at the end. 0 represented a goal ‘not met at all’ and 10 represented a ‘goal reached’. This data is presented below (Figure 6):

Figure 6: Identified GBO’s at the start and end of the intervention

Referred Child	Referrer’s concerns	Parent’s Goals	Score at the start of the intervention	Score at the end of the intervention	Increase in reaching identified goal
Archie	Anxiety	To reduce or help manage Archie’s anxiety	4	6	2+
		To better support Archie through transitions	3	6	3+
	Toileting	To improve Archie’s toileting	1	5	4+
	Particular about food				
	Difficulty in sleeping				
Bonnie	Difficulties separating from parent	To reduce or help manage Bonnie’s anxiety	1	5	4+

	Emotional outbursts	To reduce or help manage Bonnie's challenging behaviour	0	5	5+
	Sleeping difficulties				
	Feeding difficulties				
Carl	Aggression at nursery	To help manage Carl's aggression	1	8	7+
		To help manage Carl's behaviour in school	1	6	5+
	Animal mimicking behaviours	To understand Carl's animal mimicking behaviours	1	7	6+

The goals were collected by speaking with each parent. This process overall highlighted areas of agreement about the nature of the concerns held by the referring clinician and parent, though there were some areas of deviation between the referral and the parents' identified goals. The referrers for Archie and Bonnie both identified areas of concern that the parents had not. The parents for Archie and Carl identified goals that had not been included within the referral.

Whilst completing the review GBO's, Bonnie's parent commented "we understand it more" when reviewing the goal of reducing or helping to manage her challenging behaviour and commented that they felt “supported by the intervention”. Carl’s parent was focused on how best to support him as he transitioned from nursery to primary school. They commented that at the start of the intervention that they felt they had “no understanding” of his aggression. This could account for the large increase in reaching an understanding around this particular goal.

I later reflected upon the parents’ goals in relation to the child’s journey through the paediatric diagnostic pathway. All three children had received a foundation of paediatric support prior to referral to the brief parent-children intervention, often consisting of input from a paediatrician, occupational therapist and speech and language therapist following input from universal health visiting services. Despite this level of professional support, all the parents sought to understand their child’s emotions and behaviour better. A neuro-developmental diagnosis may have provided them with some understanding of the context of the child’s behaviour had a diagnosis been appropriate, however the child would likely still have been discharged from the paediatric service and they would not have been provided with a clinical space to consider the impact of this upon their child, and upon them as parents.

Strengths and Difficulties Questionnaire

The Strengths and Difficulties Questionnaire (SDQ) is “a brief emotional and behavioural screening questionnaire for children and young people. The tool can capture the perspective of children and young people, their parents, and teachers. The twenty-five items in the SDQ comprise of five scales of five items each” (CORC: 2021)

The scales include:
1) Emotional symptoms subscale – clinical cut off is a score of 5 or more
2) Conduct problems subscale – clinical cut off is a score of 4 or more
3) Hyperactivity/inattention subscale – clinical cut off is a score of 7 or more
4) Peer relationships problem subscale – clinical cut off is a score of 4 or more
5) Prosocial behaviour subscale – clinical cut off is a score of 4 or below

The pre and post brief intervention SDQ scores are detailed below (Figure 7):

Figure 7: Pre and post intervention SDQ scores for the three referred children

	Emotional Symptoms	Conduct Problems	Hyperactivity/ Inattention	Peer Relationships	Pro-social behaviour
Archie					
Score prior to intervention	7	4	7	4	7
Score after intervention	8	3	5	3	10
Bonnie					
Score prior to intervention	8	8	10	3	7
Score after intervention	7	8	8	2	5
Carl					
Score prior to intervention	4	8	10	6	1
Score after intervention	2	8	10	3	6

Scores reaching clinical cut off are highlighted in red; borderline scores are highlighted in amber and unlikely concerns are highlighted in green.

The strengths of the SDQ are that it is considered a valid and reliable measure which is sensitive to change in short term interventions. The measure also assesses both internalising and externalising behaviours. (Early Intervention Foundation: 2020). Limitations of the SDQ measure have been documented regarding its use with children who may have more than a mild learning difficulty. Mixed results have also been reported regarding the internal consistency of correlation of items within the scale. Total screening scores have been noted to only be used for screening purposes (Mieloo et al 2012).

From the findings, Archie‘s parent perceived he had made progress in four of the five domains screened – conduct problems, hyperactivity/inattention, peer relationships and pro-social behaviour. Bonnie’s parent perceived she had made a small amount of progress in three of the five domains screened – emotional symptoms, hyperactivity/inattention and peer relationships. Carl’s parents perceived he had had made progress in three of the five domains – emotional symptoms, peer relationships and pro-social behaviour.

Parents were also asked to provide information at the start and end of the brief parent-child intervention regarding the severity of the child’s difficulties, the length of time the difficulties have been present, how much and in what ways the difficulties impact on the child’s life and family.

Findings from the SDQ overall difficulty scoring and impact on life data at the start of the intervention is detailed below (Figure 8):

Figure 8: Findings from SDQ overall difficulty and impact on life data collected prior to the intervention

	Archie	Bonnie	Carl
Severity of difficulties	Definite	Severe	Severe
Length of time of difficulties	Over a year	Over a year	Over a year
Distress caused due to difficulties	A great deal	Quite a lot	A great deal
Impact on home life	A great deal	A great deal	Quite a lot
Impact on friendships	Only a little	Quite a lot	A great deal
Impact on learning	Quite a lot	Only a little	A great deal
Impact on leisure activities	Quite a lot	A great deal	A great deal
Impact on whole family	Quite a lot	A great deal	Quite a lot

Findings from the SDQ overall difficulty and impact on life data at the end of the intervention is detailed below (Figure 9):

Figure 9: Findings from the SDQ overall difficulty and impact on life data collected after the intervention

Deterioration in scoring is highlighted in red. Improvement in scoring is highlighted in green.

	Archie	**Bonnie**	**Carl**
Since coming to the intervention how are your child's problems?	A bit better	About the same	A bit better
Has the intervention been helpful in other ways?	Quite a lot	Quite a lot	Quite a lot
Severity of child's difficulties over the last month:	Minor	Severe	Definite
Distress caused to child due to difficulties:	**Quite a lot**	Quite a lot	**Quite a lot**
Impact on home life	**Quite a lot**	A great deal	**Only a little**
Impact on friendships	Only a little	Quite a lot	**Quite a lot**
Impact on learning	**Only a little**	**Quite a lot**	**Only a little**
Impact on leisure	Quite a lot	Not answered	Not answered
Impact on whole family	Quite a lot	A great deal	**Only a little**

Two of the three children referred to the brief parent-child intervention were considered to have made positive improvements over the course of the intervention. Bonnie's parent reported a lack of improvement in all areas despite being closer to their desired goals and the perceived improvements captured in the post intervention SDQ scoring provided by the parent. In particular, they noted an increased impact they felt upon Bonnie's ability to learn despite teaching staff at the time raising no concern about this in school. On reflection this may have been due to the difficulties that Bonnie experienced within her family in the context of greater complexity than the brief work could address as outlined in the Narrative chapter.

The findings from the clinical intervention elucidate the types of difficulties that a brief parent-child intervention can be effective in addressing. By supporting parents to gain an understanding of the child's emotional communication observed through their behaviour, the negative impact of this behaviour can be felt less severely.

Parents were also invited to complete an 'Experience of service' questionnaire following completion of the intervention. Two of the parents returned a completed questionnaire. The findings are presented below (Figure 10):

Figure 10: Findings from the Experience of Service questionnaire

Question	Archie	Bonnie
I feel that the people who have seen my child listened to me	Certainly true	Certainly true
It was easy to talk to the people who have seen my child	Certainly true	Certainly true
I was treated well by the people who have seen my child	Certainly true	Certainly true
My views and worries were taken seriously	Certainly true	Certainly true
I feel the people here know how to help with the problem I came for	Certainly true	Partly true
I have been given enough explanation about the help available here	Certainly true	Partly true
I feel that the people who have seen my child are working together to help with the problem/s	Certainly true	Certainly true
The facilities are comfortable	Certainly true	Certainly true
The appointments are at a convenient time	Certainly true	Partly true
It is quite easy to get to the place where the appointments are	Certainly true	Certainly true

If a friend needed similar help, I would recommend they come here	Certainly true	Don’t know
Overall the help I have received is good	Certainly true	Partly true

The questionnaire also provided a space for the parent to comment in their own words on what was “really good about their care and what they didn’t like or thought could be improved and anything else they wanted to say”.

Archie’s parent stated

> *Our child was treated with care, patience and allowed time to process his feelings and struggles. There was space for all of us in the sessions to discuss what support was needed. He has made good progress in the time he has attended the sessions.*
>
> *We are grateful that the support has been extended in line with our child’s needs and we weren’t left with no support. Also, staff have provided support and arranged meetings with school/pre-school to ensure continuity of care which has really helped.*

Bonnie’s parent stated

> *I was made to feel like we were understood and not alone.*

Carl’s parent did not return the questionnaire but written feedback was received from them at the end of the brief parent-child intervention

> *You have been such a big support throughout. Many thanks for all you have done for Carl and giving me confidence in helping him at home too.*

5.2 Part B: Findings from the semi-structured interviews with referring community paediatric clinicians

I will now present the research findings from the semi-structured interview data with the three referring community paediatric clinicians. As previously identified, the clinical model of paediatric services in the locality in which this research was based was a multi-disciplinary assessment model involving Paediatricians, Occupational Therapists and Speech & Language Therapists. The three research participants were either qualified Occupational Therapists or Speech and Language Therapists.

Data from each research participant was coded as:

- C1 (“Clinician 1”)
- C2 (“Clinician 2”)
- C3 (“Clinician 3”); followed by the transcription line count.

The case examples of the referred children discussed within the transcripts were presented in greater detail within the Narrative chapter. At the end of this chapter, I will briefly summarise the findings. Further wider discussion of the findings will be explored within the Conclusion chapter.

During the process of data analysis, I grouped together the super-ordinate themes from the emerging sub-themes across the three participants. I will now present the findings for each super-ordinate theme.

5.3 Super-ordinate theme 1 – “A whole massive resource that we can tap into. It’s brilliant!” - Working as a Community Paediatric Clinician

“I haven’t really looked back since” – Working as a Community Paediatric Clinician

The first research theme found that a foundation of paediatric support had been provided to all the referred children prior to their referral to the brief parent-child intervention by clinicians who were experienced in working with pre-school children.

All three of the research participants had completed training within their clinical speciality and had then taken up employment within the Paediatric Service located in the area of the research and had remained employed there.

> *I graduated from Uni in 2017 in the summer and I already had my job secured at (Paediatrics) in the April…straight after…I've only been in (names Paediatric clinic) since I graduated…they've sort of seen me through which has been lovely.* **C1 46; C1 48**
>
> *I ended up having a placement when I was in university in the team I'm in now and then when I finished university they offered me a job if I was interested and so I went for the interview and got the job and I haven't really looked back since really.* **C2 35**; ***C2 37***
>
> *So I qualified in er…20….13, so I started my role in 2014…in January 2014 yeah…pretty much…yeah, so yeah my first and only job has been at (names Paediatric Clinic).* **C3 25; C3 27**

Research participants spoke of the richness in resources within the paediatric service. There was a sense of support from a range of clinically trained members of staff which included occupational therapy, speech and language therapy, paediatricians, community nurses, dieticians and those specialising in supporting children with learning disabilities. These clinicians were arranged into clinical pathways. The research participants spoke of their knowledge of the neurodiversity pathway, aimed at providing assessments related to social communication such as autism, ADHD and sensory disorders. Research participants also had knowledge and experience of clinical pathways to consider a child's sleep and behaviour. In addition, some of the clinicians spoke of their work within the neuro-disability, congenital or acquired neurological conditions pathway. As one research participant exclaimed, "*a whole massive resource there that we can tap into. It's brilliant!" (*C2 127)**.**

All three research participants were involved in the neuro-developmental diagnostic assessment of pre-school children, as well as providing specialist interventions within their discipline. The clinicians spoke of their specialisms within paediatrics and training in undertaking Autistic Spectrum Disorder diagnostic assessments. One of the clinicians also worked with young children with cerebral palsy and other congenital neurological conditions. There was also a range of experience working both with pre-school and children in early years and school settings. The research found that all the participants were using their clinical skills and experience in a range of ways to assess and provide therapeutic support to the paediatric service. They all expressed having had a long-term commitment to their service following qualification and a sense of feeling loyal and supported within the service.

“They come to us wanting a bit of a magic wand” - Working within clinical and organisational limitations

Despite the richness of resources described by the research participants, they also spoke about the emotional impact of working within a service that was in high demand and needed to limit its resources at times to meet the needs of the children referred

> *What more can we offer….we see so many children….* **C1 69; C1 72**
>
> *…[and] when we don’t know the answers it’s quite hard.* ***C1 174***
>
> *There are so many children…* ***C2 56***

In addition to feeling the emotional impact due to the number of children requiring a paediatric assessment or support, research participants also shared their experience of at times feeling as if their training and experience had not equipped them to work confidently in their field of work

> *I can definitely imagine having children in the future where I may feel that they have additional needs where I feel I can’t meet their needs.* **C1 166**
>
> *It’s not until you unpick it that you realise that it’s something bigger and its not really in my remit to look at the psychological kind of aspects as I’m not a psychologist.***C2 119**
>
> *I guess just that managing behaviour and those different types of behaviour presentations. I think that’s something that is a bit of a gap in our service.* **C3 81**

Having the appropriate skills to communicate with parents was specifically raised by two of the research participants:

> *I sometimes don't feel very confident talking to the parents.* **C1 170**
>
> *Families don't want to talk to strangers about things like that either, you've got to build that rapport up…three sessions isn't enough to build a rapport.* **C2 123**

Despite the research participants having an appreciation for the range of services that could be provided by the Paediatric service, at times an experience of feeling resigned to working within organisational limitations was found. Children who were referred to the paediatric service were triaged into whichever clinical pathway suited what was assessed to be their primary need, either in terms of a diagnostic assessment or further support to alleviate a symptom, such as poor sleep or behavioural difficulties. Children referred for a diagnostic assessment were offered three appointments within the assessment nursery where they and their parents were observed for aspects of their social communication, physical development and sensory needs,

> *…'cause we can only do that in the three weeks…a short amount of time…purely because of time constraints we can't really explore that much…(so) looking at what their primary need is and working on that thing first …* **C1 75; C1 76; C1 78; C 1 110**
>
> *I've always found that there has been a need for that mental health support….We certainly have a lot of children that are showing with anxiety and the challenging behaviour stuff and we try and implement what we can.* **C2 54: C2 138**

There was also some awareness of limitations due to the commissioning of services which could enable, or hinder, a clinician being able to provide a more tailored service utilising their clinical training to support a child. Clinician 2 spoke of their dual role regarding working with Bonnie as they were involved in assessing Bonnie within the neuro-developmental pathway to consider autism, as well as being commissioned by Bonnie's school to provide occupational therapy to Bonnie. This enabled the same clinician to observe Bonnie within the paediatric clinic, as well as undertake an observation of her within her school. This was highlighted within the interview as "quite unusual" and co-incidental rather than being an aspect of a service that could be flexible and consider how a child may present within differing environments. Clinician 3 also spoke of the ending of certain community paediatric services when a child started primary school. As Carl was provided with an Educational Health Care Plan (EHCP) when he began school, the responsibility for his ongoing speech and language support fell to the school, rather than the paediatric service. In this sense there was a disconnect in the continuity of community services provided once a pre-school child entered education. This was an additional way in which children were discharged out of the paediatric service which I will say more about later in this chapter.

In response to how aspects of service limitation were experienced, one research participant had creatively forged links with external agencies they could sign-post parents to as a means to providing additional support. Clinician 2 spoke of researching charities that could provide additional support to children and their families. Although they spoke positively of the work that could be provided by such resources, they were aware that these too were neither free, nor local.

> *…they are privately funded and yeah that's the only that I know…they are still quite far away…if there is anywhere closer…I've yet to find them (laughs)….* **C2 97**

The use of paediatric diagnostic assessments, often followed by discharging children from the service, were two key mechanisms identified in the research to try and manage the demands on the service. The lack of community support available to families whose children had received a diagnostic assessment concerned the research participants

> *A lot of the time I personally sometimes feel we are saying 'we appreciate your concerns but we're not giving you a diagnosis, end of the pathway, see you later' and they're closed.* **C1 87**
>
> *Some families will, you know, be very much prepared to have a diagnosis, and been wanting it for years, but others can may not be so prepared and actually having that support intervention after the diagnosis would be really beneficial… Once they receive that diagnosis, or not as the case may be, they are discharged from the pathway.* **C3 97: C3 76**

Research participants also acknowledged that the child's journey through triage into the diagnostic assessment pathways could at times feel confusing for the child's parent. One research participant recalled the confusion that some parents experience attending their first appointment and feeling unaware of what their child is being assessed for

> *Some parents have come in and they go ‘Oh, I thought I was here for ADHD, I didn’t know I was here for ASD’ and then you have to go through the process...* **C1 109**

The research also found that for the participants there was concern about the possible focus on diagnosis and, at times the pressure experienced to provide a neuro-developmental diagnosis by some parents.

> *[Mum] was very keen on this ASD diagnosis and wanting that kind of label and it was evident when she came into the clinic for the ADOS assessment that that’s what parents were thinking…. but when we kind of went through the history…there were so many other different bits, we were just really concerned that this could actually be something else.* **C2 81; C2 82**

This pressure also raised the possibility of prematurely diagnosing or misdiagnosis occurring. Research participants spoke of the possibility to provide support initially to a child displaying traits of autism, rather than providing a diagnosis. Despite this, the pressure of parents’ desires to receive a diagnosis was in strong evidence and also related to research participants expressing feeling complained about and needing to repeat diagnostic assessments

> *(I) wasn’t pressured into making a diagnosis…’cause what was happening ‘cause mum, or parents, wasn’t happy with the outcome because she didn’t get the diagnosis that she was kind of looking for we were just going back to re-assessing, so a complaint would come in, we’d have to deal with it.* **C2 111; C2 113**

The research also found that only those children who required a medical intervention were routinely held open to the service. The possible impact of discharging after completing a diagnostic assessment appeared to be that children were then re-referred into the service at a later date and there seemed to be a limited view of alternatives that could be offered

> *When Carl came through the neuro-developmental diagnostic pathway and completed that and I think it was about six months later when nursery wanted to re-refer…that was when we thought, ‘Oh actually, we don’t think he’s appropriate to go back through the neuro pathway.* **C3 63**

Not only were the children and families experiencing a sense of being stuck, but the research found that the paediatric response too was at times stuck in a repetitive cycle of assessment of a possible neuro-developmental condition. There appeared little resource available to consider alternatives regarding the parent-child relationships and attachments, rather than locating the difficulty entirely within the child.

5.4 **Super-ordinate theme 2 - Paediatric Clinician's view of child psychotherapy**

“Sounds like a good link we could have now” - Collaborating with Child Psychotherapy

The second super-ordinate theme finding related to how the research participants experienced working with a Child Psychotherapist. All the research participants spoke of their lack of experience of working with and fully understanding a child psychotherapy approach. In response to being asked if they had any prior experience of working with a Child Psychotherapists the responses included

> *...never really worked alongside psychotherapy…no, not with under-fives...I always thought it was a lot older that they kind of got involved with.* **C2 44; C2 46**
>
> *No, I hadn't at all…This is the first time…so yeah, really fortunate to be able to do it.* **C3 42; C3 44**

This finding matched the experience of the parents who also had no prior experience or knowledge about child psychotherapy. None of the parents had any pre-conceptions about what a Child Psychotherapist may do, or how this may differ to other therapeutic clinicians they had already worked with during their child's journey through specialist services. This research finding highlighted the continuing need for child psychotherapy as a profession to raise its profile as a clinical discipline.

This finding is in the context of the geographical location in which the study was set. In the UK, psychoanalytic Child Psychotherapy continues to be a relatively small clinical discipline with around one thousand Child Psychotherapists currently registered to practice within the UK (Figure from the ACP). This figure included trainee, retired and non-working therapists. In comparison, the Health & Care Professions Council (HCPC) had almost 24,000 registered Psychologists in the UK in 2021. Geographical variation in the number of Child Psychotherapists practicing in certain areas of the UK also existed. The study was located within an area in which only one ACP qualified Child Psychotherapist was based. If the study had been set in a major city, this research finding may have differed to reflect more knowledge and familiarity for both the parents and research participants due to the greater proportion of Child Psychotherapists working in larger cities.

A key research finding was that all the research participants spoke of a wish to work further in collaboration with Child Psychotherapists to provide support to each other, the referred child and their family,

> *…sounds like a good kind of link we could have now…yeah.* **C2 44**
>
> *It's just nice to be able to have a bit of an insight what your role is and what you offer and being able to kind of use that for referrals going forward.* **C3 107**
>
> *I've always said that it's the favourite part of my job…all the multi-disciplinary working…I love working with other professionals.* **C3 117**

Although it was not possible to evidence findings regarding a longer-term process of learning in this research study, the study did find an enthusiasm in the research participants who were open to further collaboration and understanding of the clinical skills and benefits that working with Child Psychotherapists could provide which I will now move on to consider in greater detail.

"It's like looking through a different professions eye" – A mechanism for learning

As none of the research participants had prior experience of Child Psychotherapy, provision of the brief parent-child intervention was an opportunity to showcase an approach Child Psychotherapists provide and demonstrate how this work could contribute to paediatric clinicians' assessments. Through reading the clinical formulation report, research participants noted the use of clinical observation used during the intervention to help aid an understanding of what the child's difficulties may be communicating about the nature of parent-child attachments and relationships in the family. They were also able to link how a child's play and interactions in the sessions could symbolise how the child related to their relationship to parental figures and the world around them.

Initially, research participants reported that they viewed the intervention as something they felt uncertain about and this impacted on their confidence to speak with parents about referring to the intervention. There were also a range of pre-conceptions held about Child Psychotherapy. Concepts such as working in a longer-term manner; with older children and being focused on 'looking back' or taking an in-depth approach to thinking about a child's development were aspects that were raised within the research findings. 'Psychotherapy' and 'psychology' were often used as inter-changeable terms by the research participants, and I reflected that there was still a degree of uncertainty about what made a Child Psychotherapists training and clinical practice different from that of colleagues in Clinical Psychology.

The research found that there were ways in which Child Psychotherapists could engage with other clinical disciplines to help to inform about the work of Child Psychotherapy. Prior to the intervention being offered to the paediatric service, a number of initial meetings and attendance at their neuro-developmental assessments was undertaken. Research participants confirmed that having these opportunities to meet with the Child Psychotherapists who offered the brief parent-child intervention helped them to understand the intervention better

> *I think until you meet someone and actually hear from them what the service is. I was a little bit unsure but yeah definitely you coming to the meeting helped me understand what I would be referring for…I definitely think that consolidated it.* **C1 62; C1 63; C1 64**

> *Often there are all these services out there and sometimes we need to really, you need to do it don't you before you understand what is going on. I'd feel more confident talking to parents about what is on offer because I've seen it happen before.* **C1 163: C1 167**

The participants all commented on the learning opportunity that referring children to the intervention had been for them in broadening their understanding of Child Psychotherapy and the brief intervention offered. Participants considered how a

Child Psychotherapy approach differed from their own clinical training, as one participant commented

> *…taking it right back to when he was born, that was something that purely because of time constraints we can't really explore that much. We (consider) what can we do right now, whereas the psychology approach looks back at why they are doing it which was really interesting to read.* **C1 78; C1 79**

Research participants were also able to experience how the intervention focused not only on detailed aspects of the child's development, or play within clinical sessions, but that a macro perspective upon the family's functioning, and parenting styles, was also crucial to understanding what the child's behaviour may have been communicating. This parallel approach to clinical work was evident to this research respondent

> *…it's not until you unpick it that you realise that it's something bigger…I find it fascinating…I'm not a psychologist, so yeah I think that definitely did help learning about that bigger picture.* **C2 119; C2 120**

Possibly in relation to participants' own anxieties about speaking confidently with parents, as previously detailed, the research found an appreciation from participants of the clinical skills of Child Psychotherapists to speak sensitively, yet directly, with the families who were referred. One research participant referred to this as "rapport" and conveyed a sense of the importance of rapport being established but felt that this was not possible to achieve within the constraints of their own time limited assessment of the child usually over three sessions

> *The information you have actually got out is really quite impressive seen as though you haven't seen (Bonnie) that much. …It seems that you did seem to get some rapport there because they have spoken and they have told you things and that does help in building that picture* **C2 124; C2 125**

I reflected that this finding related to a clinical skill that may be hard to quantify yet is hugely important in Child Psychotherapy through the consideration of the transference relationship. The core clinical training of Child Psychotherapists is distinctive to other clinical approaches due to the ability to identify and respond to both negative and positive transferences within every clinical contact. Within under-fives clinical work this ability remains central to enable the psychotherapist to consider the way the parent is relating to their child, their partner and to the psychotherapist.

While I was working with Bonnie and her parents, clinical supervision was important to consider these transference interactions within the clinical sessions. I was able to consider my experience of the changing nature of my relationship with Bonnie's mother, and how this gave me some insight into how Bonnie also experienced her mother. From the second clinical session, I experienced feeling out of tune with Bonnie's mother as I attempted to re-cap how we had thought about Bonnie in the previous session. I sensed a 'mis-step' in our dance (Stern: 2004) as I tried to find my way back to connecting with her mother's ability to reflect on Bonnie's difficulties being understood in the context of experiences in the family. As this connection was re-established, often a third of the way into the session, I experienced a shift and a softening in the transference relationship where connections could once more be built upon, but with the concern that they may be lost by the time we met again. I could relate to Clinician 2's own difficulties to establish what they referred to as "rapport" but also consider the difficulty for Bonnie in being able to establish a secure and consistent relationship with her mother.

Providing such insights into the clinical work of Child Psychotherapists through the intervention, enabled the research participants to report feeling more confident in how they would communicate with parents about the role of child psychotherapy and how the intervention could help children referred in the future.

> *Seeing how positive it has been for Archie, it makes me feel more confident in talking to parents in the future about it, yeah.* **C1 75**

> *Every day is a school day...every day you learn new things, just by reading the report you're learning things from (it). It's looking through a different person's eye, or through a different professions eye…and the more we learn and develop and know each others' roles, the better quality of referrals you should be getting.* **C2 144; C2 145; C2 146**

> *Knowing that what Carl and his family have got from it and that actually you know they have taken away various things from it.* **C3 107**

Research participants also spoke of their willingness for their experience of the clinical intervention to influence their own clinical practices in the future.

> *It helps us learn as well and learn and develop our practices and gives us tips about what we should maybe be doing or should be looking at.* **C2 134**

Although only a relatively small number of referrals had been made to the brief parent-child intervention, the research found a willingness in research participants to acknowledge that professional links were being strengthened through the intervention and there appeared to be an appetite for continued closer working links,

> *Sounds like a good kind of link we could have now.* **C2 44**
>
> *Just move your building next to ours…or we'll move our building to you!* **C2 129**

It was pleasing to observe that referrals continued to be made to the intervention after the research study was concluded, and that the research participants in particular felt able to discuss possible referrals with the Child Psychotherapists offering the brief intervention.

5.5 Super-ordinate theme 3 - "A breath of fresh air" - Experiences of the brief parent-child psychotherapy intervention

"Influencing those next steps...rather than going round and round in circles" Reasons for accessing intervention

Reasons for research participants referring to the intervention appeared to relate to an experience that there was little left to offer the referred child from a paediatric service perspective

> *We felt from the first week that Archie wasn't presenting with ASD….so it's working out what other way can we support this family, especially because they wanted the help.* **C1 67**
>
> *Definitely the brief intervention work…influencing those next steps we need to do rather than kind of going round and round in circles.* **C2 112**

> *We thought this intervention would be really helpful for parents and for nursery and it felt it was more appropriate than going back through the ASD pathway again… we felt this would be a better option at the time.* **C3 63; C3 65**

Despite the difficulties and limitations in relation to the paediatric service, or their own clinical skills and training encountered by the research participants, the research found a commitment to supporting children and their families. The theme of wanting to support parents to understand their child better was evident and appeared to be a key motivation in referring children to the brief parent-child intervention

> *I was hoping for parents to understand Bonnie's needs a bit more…. Having seen Bonnie in the environment in Paediatrics and at school, and hearing kind of parents' story…..yeah...you really wanna support (laughs)...and mostly kind of getting parents to understand her needs.* **C2 61; C2 65**

The research found that participants often worked in a complementary way to that of Child Psychotherapy. Participants spoke of their experience of considering a child's developmental history and using a systemic focus at times to help them and the parent consider what was happening outside of the child's individual experiences

> *I think looking back at early childhood and what might have happened… to better explain…All the difficult behaviours came at the same time that his baby sister was born and Mum didn't seem to link the two together and I feel that actually some looking back at 'well what happened at that time?'…Looking at the family as a whole… rather than just what the child is doing…* **C1 118; C1 120; C1 122; C1 123**

Despite the participants' wish to support parents to understand their child better, the research found that participants had varying views in relation to the referred child. Additionally, this relationship could differ from before and after a referral to the brief intervention. At times, the research found that it was difficult for the referring clinician to hold the referred child in their mind

> *When you emailed with his name, I thought 'Oh no, who's this? (laughs).* ***C1 54***

> *To be honest…I'm not sure because I know Carl has gone to school so I'm assuming he'll still be open to the therapist, the Speech and Language Therapist*

> *there…From my point of view I've obviously not had any more dealings since last summer really.***C3 69; C3 71**

Research participants also spoke of a greater sense of ownership towards the children they had worked with as their allocated therapist, rather than only being in contact with the child purely by offering a diagnostic assessment. Research participants referred to this as being a child's "named therapist", and in turn the child was experienced as "named" in their minds more firmly.

The research participant's view of the child's parents, who may have been held more vividly in mind, also appeared to influence the degree of support that the research participants wanted to offer

> *It was (Archie's) parents who were really concerned so we wanted to make sure that we gave them the right service….so it's working out what other way can we support this family especially because they wanted the help.* **C1 67**

> *She's such a well engaged Mum and they are such a great family trying to do anything they can to support Carl and they'll take any recommendations on board.* **C3 67**

I felt that this research finding related to the strength of the working relationship that had been established between the research participant and the child's parent. Those parents that appeared to be engaged and motivated to accept help and support appeared to be more likely to receive it. Further consideration of how those parents who struggle to work collaboratively at times with professionals, yet whose children also require services to support them, may be disadvantaged in some way. Further research into the importance of the counter-transference of clinicians working with families would be of benefit.

Prior to the start of the research study, I also felt that there was in part a degree to which the sending of referrals was not too deeply considered by the paediatric team. Instead, the opportunity to refer children to the brief intervention, who had exhausted what the paediatric service could provide, was also evident. Limited resources and skills within the paediatric service was indeed a motivator for referring to the intervention which the research findings supported. An appreciation that a longer-term intervention may have been needed for the whole family could also have been a factor in this decision.

The foundation of establishing a collaborative way of working between paediatrics and Child Psychotherapy was possibly realised within initial meetings held to discuss the possible provision of the intervention. At these meetings, I observed my paediatric colleagues partly held a sense of disbelief that we as clinicians were seeking out additional referrals from the paediatric service. Their understanding of this was that as Child Psychotherapists we needed experience of working with young children within our clinical training which was indeed accurate. This in some way made the collaboration feel more reciprocal in that the CAMHS service were agreeing to provide an intervention to young children who may not ordinarily have been accepted into the service were it not for the training needs of the Child Psychotherapists working there. An additional key finding from the interview data was that there existed a wish in paediatric clinicians to work more collaboratively with CAMHS clinicians.

The motivations for referring a child to the intervention were therefore more diverse than my initial assumptions. Prior to the research study, I had considered the main motivation for referring would be linked to a lack of suitable emotional wellbeing support in the locality for children who were of pre-school age. Through my own awareness of the context of local services, I was also aware that those services commissioned to work with this population rarely did, either due to other demands on the services, or a lack of skilled clinicians who could provide a service to these young children and their families. A gap in service provision between what could be provided by universal services, such as health visiting and school nursing, was only partially being met by paediatric and CAMHS. There were also contributing factors relating to how the referrer perceived the child and their parent. Additionally, a number of further benefits were identified by research participants which I will now move onto consider.

“Your stuff trumps our behaviour stuff!” - Benefits of the parent-child intervention

Provision of the brief parent-child intervention was based on a hypothesis that the intervention would be beneficial to both the referring clinician and the referred child and parent/s receiving the intervention. The research confirmed that all three participants experienced the brief parent-child intervention as beneficial.

All the research participants provided positive feedback about their experience of referring the child to the brief parent-child intervention,

> *I think there is a huge place for it.* **C1 81**
>
> *Your stuff trumps our behaviour stuff*. **C2 104**
>
> *Wonderful!* **C3 104**

The research findings identified four reasons why the research participants experienced the intervention as beneficial. These were i) an alternative to discharging without support; ii) confirming a paediatric clinical opinion regarding the referred child; iii) helping to avoid possible misdiagnosis of the referred child and iv) providing a clinical formulation should the child be re-referred to paediatrics. I will now present the findings for each sub theme.

The research identified that the intervention was an alternative to the paediatric clinician discharging the child without further support being offered. The possibility of referring a child to the brief parent-child intervention provided the research participants with an alternative to discharging without the offer of further paediatric support being offered to the referred child and their parents,

> *With Archie we were able to go 'look we're not diagnosing but we are going to offer something additional' and it felt like a really natural way to go.* **C1 88**
>
> *I think it helped us come to a decision to be honest. I think without it parents would have had a lot of questions.* **C1 138; C 139**
>
> *(I) felt confident that the parents would be supported ongoing and after they were closed to us.* **C1 146**

The degree to which children were discharged from paediatrics, following completion of a diagnostic assessment**,** was a major aspect of the research findings which had not been envisaged at the start of the intervention. When the intervention had been provided within a previous geographical location, this was not the case. The lack of paediatric follow-up with the referred child in two out of the three children in the research sample was indicative of this practice.

From my own experience of diagnostic services within CAMHS, I was aware that this trend had been evident for older children receiving a neuro-developmental diagnosis such as ASC, as the children in the intervention cohort had experienced. There was little additional mental health provision provided by specialist mental health services, unless the young person was experiencing a co-morbid mental health difficulty. Otherwise, the young person and their family were often signposted to national charities and short-term initiatives to provide support and understanding to families experiencing the impact of a neuro-diverse diagnosis.

Second, research participants felt that the intervention and subsequent clinical formulation report confirmed their clinical view of the referred child and therefore upheld their own clinical decision making

> *I think the things that you focused on - They were all things that we picked up on so actually to have them worked on in more depth - 'cause we can only do that in the three weeks.* **C1 73: C1 74; C1 75**
>
> *I feel that because your intervention was there for us to offer it really helped us to feel confident with our decision.* **C1 145**
>
> *I think definitely its influenced (our treatment plan)… we were kind of right in our thinking but it does help that actually you guys have seen similar kind of difficulties that we have… definitely the brief intervention work (helped) cause it kind of clarified what we were thinking as well.* **C2 110; C2 112**

Third, a possible link between the use of the brief intervention and avoiding mis-diagnosing children was found. Archie's referrer spoke of the similarity in his presentation to that of a child who may be diagnosed with autism. They spoke of "surface like ASD" and how children can present for a diagnostic assessment with such behaviours. The possible uncertainty of whether a child was presenting with autistic traits, or their behaviour was more akin to attachment difficulties, or a combination of both is an area of acknowledged clinical difficulty. To help to address this the 'Coventry Grid Interview' (Moran: 2010) was devised. The Coventry Grid Interview presented differences in behaviour between children with autism and those with significant attachment problems.

The value of the brief intervention in these circumstances was that a Child Psychotherapy clinical formulation may provide an alternative view of why the child was presenting with traits of autism, or autistic defences from a psychoanalytic perspective, rather than meeting the diagnostic criteria for an autism diagnosis. Child Psychotherapy was considered by the research participants to have the skills needed "to really dive in and get all the information" (C2: 121). The possibility of the child being wrongly provided with a diagnosis of a "lifelong condition" (C2: 137) placed an additional pressure on paediatric clinicians to get "the intervention right first…so I would definitely refer more children." (C2 137). Flackhill et al (2017: 64) acknowledged the dilemma that this type of scenario placed clinicians in

> *Some clinicians feel paralysed about proceeding to make a diagnosis of ASD in the presence of complex psychosocial histories and sometimes a hypothesis of attachment difficulties vs ASD is seen as mutually exclusive.*

Interestingly, Flackhill et al (2017: 64) also state that

> *Early intervention for attachment disorders is likely to reduce the risk of the later development of personality disorders. Combinations of autistic and attachment difficulties will require a joint approach addressing both e.g. psychotherapy.*

Further consideration of why psychotherapy is seen to possess the necessary skills to address these complex co-morbid presentations would be helpful. This view appeared to be shared by the research participants in this study who appreciated a clinical approach where psycho-social aspects could be considered, alongside the child's presentation. It may be that Child Psychotherapists are considered to be trained, and therefore more skilled, in working in this way than other clinical trainings.

Lastly, despite referred children often being discharged by the Paediatric Service whilst the brief parent-child intervention was being undertaken, participants felt that the clinical formulation of the referred child could be helpful regarding any future assessment the Paediatric service may be asked to provide,

> *If he were to be re-referred in the future…which he might be, potentially in the future …you know that would be really helpful to have any information that they (the parent) receive going forward.* **C3 99**

"If I had a family, I'd recommend it!" – Future use of the brief intervention

The research focused on not only whether the intervention was experienced positively by referrers but the study also wanted to consider research participants' view of what emotional or behavioural difficulties they felt the intervention could support them with in their assessment of the referred child, and where in the diagnostic assessment process the intervention could be most beneficial to the paediatric diagnostic assessment.

Participants linked the possible future usefulness of the brief parent-child intervention to the number of pre-school children displaying behaviours linked to anxiety. It appeared that the skills and services needed to think with parents and children about these primitive anxieties, and how they may be understood as a communication of an emotional need, was limited. The paediatric service was primarily often considering how anxiety or aggression might relate to a neuro-developmental mental health condition

> *We certainly have a lot of children that are showing with anxiety and the challenging behaviour stuff, and we try and implement what we can. From my perspective it's a lot of OT based strategies, a lot of sensory based strategies but actually when you unpick those sensory behaviours, there's often a psychological reason.* **C2 138**

One of the research participants also linked the possible usefulness of the intervention to supporting children where there had been possible trauma experiences,

> *… there could be abuse there, there could be trauma there and that's a difficult thing to unpick on your own…as you guys have got trained for that it makes sense to refer to you guys.* **C2 141; C2 142**

This finding was linked to how the research participants expressed their concern about mis-diagnosing a possible neuro-developmental condition in situations where they were aware that psycho-social factors were also present that could be impacting upon the parent-child attachment relationship. This finding would confirm a significant gap in the training of paediatric clinicians if this view was more widely supported within the paediatric service. As there is increased knowledge regarding the impact of trauma and adversity upon a child's development and the need for services to be working in a trauma informed way, as outlined in the Introduction chapter, it may be that Child Psychotherapy continues to be considered a discipline in which these complex presentations can be more readily spoken about and explored with families.

There was a lack of clarity or consensus from research participants about where in the paediatric diagnostic process they would consider referring to the brief parent-child intervention. This may have been related to a lack of uncertainty about where the difficulties were located, either in the child or a communication of a parent-child or parental relationship issue that may need further exploration. Participant's responses ranged from the possibility of screening out referrals being sent to the paediatric service, to providing support to those families coming to terms with a neuro-developmental diagnosis,

> *I think if it's before (diagnosis) it would help with that diagnostic profile, so you've got an extra pair of eyes from a different angle.* **C2 87**

Research participants were also asked their view on whether they would recommend referring future children to the brief parent-child intervention. The key finding of the research was that they all considered the experience of referring a child to the intervention to be a positive one which they would repeat and would recommend to other clinicians and families.

> *I think there a huge place for it across the whole service to be honest…. Yeah, absolutely I'd recommend it….I can definitely imagine having children in the future where I may feel that they have additional needs where I feel I can't meet their needs.* **C1 166**
>
> *Yes, definitely yeah…even if I had family, I'd recommend it (laughs)…* **C2 160**
>
> *Oh yeah, absolutely…. we're really lucky to have the service and the opportunity to work with you so yes, definitely.* **C3 102; C3 115**

5.6 Summary

This chapter presented the findings of the study from the perspective of data derived from the clinical intervention undertaken with the referred child and their parent, followed by analysis of the interview data with the research participants.

The sample of both quantitative data from parents accessing the intervention and qualitative interview data from the paediatric clinicians is clearly a small sample which impacts upon the representativeness of the findings and will be considered in more detail in the next chapter. The findings however did evidence that paediatric clinicians experienced the contribution of the intervention to be valuable to the paediatric diagnostic assessment of children aged under-five. The emerging reasons for this highlighted how the intervention could support the paediatric diagnostic process in a number of differing ways. Paediatric clinicians experienced the intervention to be valuable in confirming their clinical view of the child's difficulties. This in part supported their wish to reduce the number of children being mis-diagnosed with a neuro-developmental diagnosis, in a context of parental pressure at times to provide a diagnosis.

The findings also presented our paediatric colleagues as eager to support children and their families better. However, limitations were identified, in particular in being able to provide support to children who did not have a neuro-developmental disorder, as well as supporting parents to come to terms with a diagnosis where it was given. Paediatric clinicians all voiced their concern at the practice of discharge following diagnostic assessment. They welcomed the opportunity to be able to provide something additional to support the child and their family.

All the referring clinicians found the experience of referring to the brief parent-child intervention broadened their limited view and experience of Child Psychotherapy. Positive progress outcomes for the referred children strengthened a view from all the research participants that they valued and would recommend the intervention. The findings also confirmed that the research participants appreciated the possibility of strengthened multi-disciplinary working through the provision of the intervention.

Although the aim of the research was not to consider the clinical value of the intervention to the referred child and their parent, the research did confirm that all the parents who participated in the brief parent-child intervention, reported benefits to their child, and increased understanding as parents, through their participation in the intervention. All the parents reported feeling the intervention had supported them to be closer in reaching their identified goals in managing and understanding their child's behaviours. The findings of the SDQ data also confirmed that all the children were considered to have improved in at least three areas of their development. Two of the three referred children were considered to have made overall improvements regarding their difficulties and the impact these difficulties had upon them.

In the next chapter I will consider these findings in a broader context within psychoanalytically related literature, research and the current landscape of the provision of mental health services for pre-school children. I will conclude by considering how this research project may relate to clinical work currently being provided by Child Psychotherapists and suggest further research in this area of clinical practice.

6 Conclusion

The aim of this research study was to consider the contribution that a brief under-fives parent-child psychotherapy intervention could have on the paediatric diagnostic assessment process. In this chapter, I will summarise the key findings of the study and discuss how these findings contributed to existing research in this area of interest. I will also consider the findings in relation to clinical practice and possible further research. I will conclude by reflecting on my experience of this research study.

Summary of key findings

The key findings from the research study were that the three referring paediatric community clinicians found the brief intervention clinically contributed to their paediatric assessment of the referred child. All the referring clinicians stated they would refer further children to the intervention and would recommend fellow clinicians to refer to the intervention also.

The context of this contribution was understood in part due to the pressure within paediatric services to assess a large number of children. This resulted in limitations in the time available to assess and support children and their parents by the paediatric service. All the children had received clinical assessment and intervention from skilled paediatric clinicians prior to referral to the brief intervention. However, all the children continued to experience emotional and behavioural difficulties that their parents sought assistance to address. Paediatric clinicians acknowledged limitations in their skills and knowledge regarding the mental health needs of children, particularly in relation to considering the impact of psycho-social aspects that may have resulted in trauma and attachment difficulties. The intervention was valued as a means of providing a child and their parent with further support when paediatric services and interventions had been exhausted. In particular, the intervention was able to support parents and paediatric clinicians regarding a child’s emotional dysregulation and developmental delay in social communication. This was evident through the emotional stuckness that was present, despite a neuro-developmental diagnosis not being appropriate in all cases.

All the research participants felt that increased collaboration with Child Psychotherapists would be beneficial. The intervention had provided them with their first experience of working alongside Child Psychotherapists and some developing knowledge about a Child Psychotherapy focus on children and their families was acknowledged. In particular, research participants valued the possibility of another clinician providing a view of a child and their difficulties. This could be due to the value in supporting an existing clinical opinion or avoiding a mis-diagnosis of a neuro-developmental condition. Research participants were undecided where in the diagnostic process the intervention would best contribute to the paediatric diagnostic assessment as benefits at varying stages were identified.

The study provided a brief psychoanalytic intervention to the referred children and their parents. As outlined within the Literature Review chapter, this approach was founded upon the pioneering clinical work of several eminent Psychoanalysts and Child Psychotherapists. The importance of their experiences and writings was invaluable in informing the clinical intervention that was provided during this study. The study found that parents could feel supported to understand and attune to their child more fully through the brief intervention. The research confirmed the findings of previous investigations of brief child psychotherapy approaches to promote positive changes in a relatively short number of clinical sessions. I will now consider how this research study related to previous research and literature with a similar focus

How does the study’s findings relate to the field of current research?

No prior research existed aimed to consider the experience of the referring clinician regarding the provision of a brief parent-child psychotherapy intervention. One of the aims of this study was to address in a small way the lack of research in this important area.

A small number of previous studies presented in the Literature Review outlined research that had been undertaken to understand what referrers experienced in relation to referring to wider CAMHS services. The majority of these focused upon GPs perceptions of referring to CAMHS services generally, rather than to a specific clinical intervention as this study was concerned with. Only one study conducted (Slowik & Noronha: 2004) considered paediatric clinician’s experiences of referring to CAMHS services. That study supported some of the findings of this study, which included a lack of paediatric referrer’s experience and training regarding assessing and supporting the mental health of young people, and a request for improved access and joint working with CAMHS clinicians.

Despite the small number of studies that have been undertaken in this area, I reflected on the findings of this research study and how they may align with the findings of these previous studies. Three themes were evident across the previous studies considering referrer's experiences and this current study. First, there was an acknowledgement by the referring community clinicians regarding their limited training, knowledge and experience to adequately assess and support the mental health needs of children and young people within their clinical roles and disciplines. Second, there was a request from referring clinicians to work more collaboratively with mental health services for children and young people and a wish for an improvement in the communication between services. Third, the limitation of services to support young people with possible mental health needs was in evidence. I will now consider these in more detail and how they related to this research study.

Limited mental health knowledge and skills

In line with the findings in this research study, the field of research demonstrated that children and young people in the community are supported by a range of skilled clinicians including GPs, paediatric clinicians, school nurses and health visitors. However, despite the range of skills and knowledge present in the participants in the studies, referring clinicians felt limited in their skills when considering mental health needs that may require further specialist assessment. O'Brien (2017) noted that GPs felt uncertain about how to screen, assess and diagnose a mental health condition; that GPs perceived mental health problems as complex, and felt that they possessed an overall lack of mental health awareness and training regarding common conditions. Some GPs also wanted more lower-level interventions to prevent difficulties escalating (Lambert et al: 2020) which would be in keeping with the need for earlier intervention with young children as this study provided.

GPs reflected on how their lack of training in adequately recognising and responding to young people's mental health needs could lead to them wrongly assess a child as having mental health needs, as opposed to considering psychosocial difficulties, family conflict and stress, as well as parental mental health difficulties. This was linked to mental health services being over-whelmed with referrals, causing young people to wait lengthy periods to be assessed. GPs reflected that if they were more able to make appropriate referrals to CAMHS services, young people with mental health needs would receive support sooner rather than over-whelming the system with referrals regarding matters outside of a child's mental health difficulties. Such a pressure on community clinicians to assess potential mental health conditions was in line with the findings of this study in which referring paediatric community clinicians acknowledged the possible pressure to provide a diagnosis and the longer-term impact that a mis-diagnosis could lead to. This related to the wider issue previously noted in the Introductory and Narrative chapters regarding where the difficulty is located - within the child or through further consideration of the child's wider psycho-social system and attachment relationships.

There was a reluctance in some GPs in the previous studies to enquire too much with parents regarding the child's difficulties. One GP felt they might, '…start to feel like I'm going a little beyond my remit because … you start to feel a little bit like you're giving parenting advice … that's quite a personal thing" (O'Brien: 2017: 891). This finding was similar to the clinician's experience in this study in relation to how confident they felt discussing such matters with parents, and how this may relate to not having the skills or time to establish a 'rapport' to have such sensitive conversations.

None of the participants in this research study spoke of seeking support from their clinical supervisors to help them manage referrals which they felt they had inadequate clinical skills to respond to, although a supportive working environment was conveyed by the participants in this study. Roberts (2013) also found in their study of GPs, a lack of clinical supervision was highlighted as an area of concern to help manage situations of uncertainty.

Similar to the participants in this study who expressed how they valued having the brief intervention available to them to support young children's emotional needs, Beresford et al (2010) noted a positive impact on the referrer's practice in being able to refer children and young people to a specialist intervention, a CAMHS for deaf children. Beresford also noted that research participants had an increased understanding and reduction in stress knowing there was a service they could refer onto.

Desire for collaboration

In previous studies, GPs noted that collaboration with mental health clinicians, alongside utilising their own skills as a parent when possible, helped to increase their confidence in identifying and referring a young person with mental health needs (O'Brien: 2017). GPs valued having a mental health professional to discuss a young person with and to decide whether a referral to a specialist mental health professional was appropriate. Participants within O'Brien's study also reflected on the importance of having a link with a clinician in the CAMHS service to enable them to discuss possible referrals. They appeared to want to make appropriate referrals perhaps due to their appreciation of the pressure that services were experiencing.

GPs were not the only clinicians to voice a wish for increased collaboration with mental health service clinicians. Stanton et al (2017) concluded that referrers to mental health in-patient units also wanted increased communication between the referrer and the unit. Interestingly, these referring clinicians welcomed the opportunity for a fresh perspective on the young person they had been working with which they felt could be achieved through a second opinion of “a fresh set of eyes” (Stanton at al: 2017:1668). This finding was in keeping with this research study in which participant's valued a different perspective on the child's difficulties. Some clinicians in Stanton's study also welcomed the opportunity for their clinical opinion to be validated by another. The desire for collaboration also supported Sutton (2006) who acknowledged the benefit of involving Child Psychotherapists in the process of assessing children (Sutton: 2002: 185) “as a tool to contribute to diagnostic clarification”.

This study originally intended to strengthen the links between paediatric and CAMHS services through the provision of the brief intervention at the paediatric clinic. Unfortunately, this was not possible as previously outlined, however existing research in this area suggested that this would be an area to consider further. Lambert et al (2020: 5) found that GPs also felt this type of collaboration between services would be preferred by families

> *It works well because patients like to come here. They don't like going to different clinics and things … As soon as they go to mental health clinic, they know that everyone's calling them crazy. Whereas they come to GP practice, nobody knows what you have come for. So, it doesn't matter which worker you are coming to see within the health centre. Nobody knows exactly who you are seeing.*

Limitations of the services

Like the participants in this study, GPs in previous studies considered part of their role was to sign-post to other services (O'Brien: 2017; Lambert et al: 2020). They too experienced high numbers of referrals of children and young people to their clinics and there was an awareness of the limitations that such primary health services could provide. Some GPs felt restricted by the amount of time they could dedicate to each appointment in their clinic. There was a sense of frustration when referrals to CAMHS were rejected, or the families were signposted back to their GP by services. GPs expressed feeling stuck in these instances "… don't really know what to do because we've referred because we're out of our depth and then it gets rejected" (O'Brien: 2017: 894). This sentiment echoed with the participants in this study who at times felt out of their depth to respond, yet parents were requesting support and the clinicians were unsure who could provide this.

Previous studies evaluating GPs experiences noted a lack of awareness of what treatment pathways could be provided by a CAMHS service and a lack of knowledge regarding clinical roles within mental health teams. One GP respondent stated "some (mental health) creatures are on the verge of being mythical beasts,…like psychotherapists,…educational psychologists" (Roberts: 2013: 4). Clinicians in my research study also expressed a lack of understanding or familiarity with the role of a Child Psychotherapist. The possible contribution that Child Psychotherapy can have in supporting these young children, parents and fellow clinicians must be caveated with the contextual reality previously raised in the Findings chapter regarding the profession being a relatively small clinical discipline. With this in mind, I will now consider the findings in relation to current clinical practice and service delivery.

Implications for clinical practice and further research

Positive experiences of the brief intervention for the referring paediatric clinicians and parents were evident in this study. The children in the intervention cohort were found to have improved in their emotional and behavioural presentations. Parents reflected upon their increased understanding of their child's difficulties, in part by considering their emotional responses to their child. Clinicians expressed a gratitude for the intervention and were eager for the intervention to continue to be at their disposal to refer to.

The training and knowledge that Child Psychotherapists hold about the nature of the child's internal world, their willingness to address parental and psycho-social factors present and an appreciation of the emotional impact that contact with a child and family can elicit in the professionals working with them, may be applied collaboratively with other clinicians working with these young children. In this study, a lack of confidence and training in such skills for the research participants was evident. In particular, research participants shared their lack of confidence in speaking with parents regarding family histories and psycho-social aspects of development, that could highlight a training area of need. Providing training or consultation regarding such important clinical skills could be an important way to support both the clinicians and children being assessed in other services.

The reality of the relatively small numbers of Child Psychotherapists trained to work in this way with pre-school children is combined with knowledge that those remaining working in NHS settings are currently experiencing an acute pressure to prioritise mental health services to large numbers of school aged children. Provision of the knowledge and skills to work in a psychoanalytically informed way through training and consultation would in part acknowledge that more widespread implementation of a brief psychotherapy intervention may not be possible to be replicated. The feedback from the research participants demonstrated the possibility of a consultation model of joint working being piloted. This could provide an additional research area in this field.

It was welcome news to hear that as this research study was concluding, the local paediatric service announced that it had received additional funding to support children with mild to moderate emotional wellbeing issues. It is areas such as this that provision of consultation and training provided by Child Psychotherapists could be further explored.

Further research within this field of interest could continue to demonstrate the breadth and flexibility within psychoanalytic Child Psychotherapy training to provide a service to pre-school children and their parents that is not always addressed through the paediatric diagnostic pathways currently available in some services. Research questions focusing more specifically upon the areas identified within this study, such as ‘how can Child Psychotherapists contribute to supporting clinicians undertaking assessments where there are suspected neuro-developmental, and/or attachment difficulties within complex psycho-social environments?’ could be considered. The provision of small clinical work discussion groups to think with our clinical colleagues about these assessments from a psychoanalytic perspective could be welcomed as a means of clinical supervision, training and containment of clinician anxieties. Due to the current use of online technologies, such innovative ways of working have become more possible to be undertaken and researched.

The paediatric service in this research study was largely commissioned to provide assessment and short-term targeted treatments to young children. One important finding was the practice of discharging children from the paediatric service following a diagnostic assessment, or a targeted piece of therapeutic work. Further discussion involving those health professions who may be more able to have an open-ended relationship with young children, such as Health Visitors or School Nurses, may be an alternative route to supporting both these young children and the professionals working with them.

Additional research may conclude that pressures on all services have severely impacted the concept of a more enduring relationship provided by a health professional to a particular child. As Daws (1999) concluded “the real application of the knowledge gained is in sharing it with doctors or health visitors who see many more families than it is possible for us” (Daws: 1999: 21). Daws was also aware at the time of her writing that referrals for young children were often “closed” to child and family clinics, as they were referred to at the time but considered GPs and Health Visitors to have a “more open-ended relationships with their patients.” I feel that even this type of consistent, longer-term relationship may not be possible for parents and children in the current climate of GP shortages, the use of locum clinicians and the overall pressure on the NHS system. Further research to consider a child's relationship with such professionals, particularly Health Visitors who are now tasked with monitoring the health needs of young children until the age of seven, could be helpful. Other avenues to explore for research possibilities also include perinatal and maternal-infant mental health services where clinicians may welcome the psychoanalytic contribution that Child Psychotherapists can provide.

I held Daw's paper in mind during the initial stages of planning this research study. Daws wrote of the experiences she encountered when Health Visitors and GP surgery staff had an opportunity to consider the emotional impact of working with some families upon the clinician. She observed the role of the Child Psychotherapist in the GP surgery as supporting clinicians to vocalise sometimes difficult feelings of irritation and helplessness encountered within their work. A culture of competence can at times hinder such frank discussions within services. It is possible the role of the Child Psychotherapist, being slightly outside of the organisation, could make it more possible for some of these personal emotions to be thought about and processed through a consultation forum.

The history of training and working as a psychoanalytic Child Psychotherapist within the UK has been a fluctuating picture. At times, external pressures have been evident upon the future of NHS funded training programmes and the variety and grading of qualified posts within NHS services. Despite some of the limitations in replicating the intervention provided in this study, it was encouraging to continue to hear that a recent increase in Health Education England (HEE) funding of four-year psychoanalytic Child & Adolescent Psychotherapy training posts had been agreed, with a continuing requirement to undertake clinical work with children aged under-five. Child & Adolescent Psychotherapy's inclusion in the twelve core psychological professions within the NHS (Psychological Professions Network: 2021) further cemented a view of the significant contribution that the profession makes to supporting children and young people's mental health.

A focus on patient participation has reflected the growing recognition within NHS services of the need to listen to the views of, and involve patients in planning, their care. The views of young people, parents and referring clinicians who have experienced the positive impact that a psychoanalytic intervention can have could raise the profile of the work that Child Psychotherapists undertake. This may be one area in which Child Psychotherapists can seek to influence an increase in the commissioning of further clinical posts and services.

As previously stated, this study involved three research participants who had not worked with a Child Psychotherapist prior to the brief intervention. Despite this, the participants held some assumptions about the way in which Child Psychotherapists had been trained and the way in which they work with children and families. Further research to consider how the profession is viewed by other clinical disciplines could open a dialogue about the way in which Child Psychotherapists are trained, undertake clinical work and seek to work in collaboration with other clinical disciplines too.

Reflections on the study

The assumption that clinical work with young children is low risk and is lacking in complexity can be a commonly held view. I have reflected at times on the wider views of the CAMHS team in which the research was based. During the research study, I heard views from fellow clinicians that ranged from questioning why such young children required mental health services, to concluding that the difficulties were all related to poor parenting. Envious feelings in relation to Child Psychotherapists having the ability, or time, to work with such young children were also evident.

However, there were also colleagues who were supportive and expressed a wish to join the clinical work that was being offered. Opportunities for Child Psychotherapists to create clinical spaces for discussion about the types of interventions being offered to these young children would expand an understanding of the importance of this work and may increase an interest for other disciplines to undertake joint work in this area. The disruption caused by COVID-19 restrictions in some way caused the research study to become invisible within the clinic when sessions were required to be offered online, removing the opportunities for colleagues to see the young children and their families in the clinic and clinical dialogues to be fostered about the intervention. However, the provision of the under-fives brief intervention to referring paediatric clinicians has continued to be made available after the conclusion of this study ensuring that opportunities to build on the possibility of joint working, both inside the CAMHS service and with the paediatric service, remains possible.

Child Psychotherapists approaching this type of intervention for the first time could feel daunted by the many clinical accounts in the literature by eminent, experienced colleagues who may appear to quickly observe and interpret what the child's behaviour may be communicating. Within this short-term work I felt some reconciling was required of *what was evident to be worked with*, and what *could* be worked with in the time frame allowed. Emanuel (2011: 673) noted that "The (Tavistock under-fives) service has expanded to include specialist longer term work reflecting the increasing complexity and greater levels of disturbance of referred cases".

Barrows (2003) also warned of the limitations of brief child psychotherapy interventions based upon models such as the Tavistock under-fives clinical model. He stated that the idea that change was possible within short spaces of time and sessions can result in the family, and the psychotherapist, feeling despondent when such change was not possible to replicate. Other writers have raised the need for the intervention to be longer than may have initially been proposed within the five sessions model (Stern: 1995). I reflected on these points and the need for further intervention for two of the three children that had been referred as outlined in the Narrative chapter. I understood the brief intervention as a means to undertake exploratory work regarding the child's presenting difficulties that then led to further clinical work being offered to support the child, parents and schools.

Technology assisted therapeutic interventions

This research was undertaken within a unique period in our history through the impact of the COVID-19 global pandemic that interrupted the delivery of the clinical intervention after only one or two in-person clinical appointments had been offered to the child and their parent. Due to this, the research took on a new focus as not only was I a novice researcher attempting to implement the research study but I was also required to provide a clinical intervention through a medium that I was not trained in or familiar with. It could be argued that the theoretical basis of the Tavistock under-fives model of clinical intervention was no longer possible. Instead, a hybrid version of undertaking clinical observation and intervention moved to the child’s home setting, a setting which is not usually exposed to the work of the Child Psychotherapist.

All three of the children and parents within the intervention cohort had attended at least one in-person clinical session prior to the national restrictions. Therapeutic engagement had been established which may have contributed to the parents supporting the transition to online sessions where possible. This may in part have been due to a wider need to connect and feel supported in the context of the pandemic which the clinicians and families had no prior experience of.

Challenges were experienced both by the clinicians and the families in transitioning to online sessions. These included sessions being forgotten about by the parents as the usual structure and routine of life was eroded; sessions taking place on parent’s mobile phones limiting the view of the child and parent; issues with audio and images freezing; the referred child choosing to not be seen on screen and frequently walking away from the observable area as well as numerous distractions of toys, siblings, pets, TV’s etc. The impact on clinical observation cannot be underestimated as this is a cornerstone in the theoretical underpinning of the under-five’s clinical intervention.

There were also challenges to overcome in relation to sessions being offered by Child Psychotherapists who at times were also working from the intimacy of their own homes and family life at times being near to intruding upon the clinical intervention. I attempted as much as possible to undertake the clinical sessions within the clinical room that I had met the child and parents in at the clinic, though at times sitting in this room surrounded by the three usually occupied empty chairs around me emphasised the disconnection that I was feeling from the clinical work I had envisaged prior to the research study beginning.

I also reflected that there was a sense of the families, and I as a researcher and clinician, waiting to resume the intervention in-person. However, the restrictions of the pandemic lasted longer than I had anticipated, and the time restrictions of the study meant that the clinical intervention could not be postponed, but instead needed to progress through this new format.

Strengths and limitations of the study

The main strength of the study was that it aimed to research an area of interest that had not been researched previously. No prior studies had been undertaken which aimed to consider the views of the referrer to a brief parent-child psychotherapy intervention. In this way, this study was original in that it attempted to illuminate an area that was not known.

This strength in the design of the study originated from previous experience of providing the brief intervention in another locality. I was aware that through this experience, paediatric staff had welcomed the intervention and that further exploration of the reasons for this could be beneficial. As I had not experienced undertaking clinical research prior to this study, I was aided by the support of both my clinical CAMHS team and the willingness of the paediatric service to support both the offer of the clinical intervention and the research study.

A further strength of the study was being able to consider the impact of undertaking both clinical and research activities online. These aspects were not foreseen during the planning stages of the study however, a strength of the inherent flexibility in the design of the study, and the willingness of the families and research participants involved to adapt to this new medium, enabled clinical sessions and research interviews to continue to be offered.

The research also benefited from the support of a second Child Psychotherapist who joined me to provide the dual parent/clinician role that is helpful but not always possible to achieve. The complexity of this type of clinical work I feel required two clinicians to sufficiently contain the family, whilst creating a thinking space. I was indebted to my co-psychotherapist in this regard who helped to emulate a co-parenting stance, enabling us to model openly thinking and wondering between us about what we were observing and hearing in the room. This need for dual working took on a new importance within online working when technical difficulties may have limited one clinician’s view or audio.

There were limitations to the study. First, due to the small sample size, it was not possible to generalise beyond the participants experiences in this study from the data findings. The main aim of the research was not to solely focus upon the value of the brief intervention, as other papers have sought to consider this aspect with much larger sample sizes, but instead to evaluate how the brief intervention might contribute to the paediatric assessment of young children. The original sample size of five paediatric clinicians could not be achieved within the time constraint of this study. However, although the sample was small, the aim of producing richly textured data from the interviews was still considered significant and of interest due to the lack of research in this area. The size of a research sample has been widely debated however, views are also presented regarding the quality of the data rather than the quantity (Sandelowski; 1995, Morse: 2002). The data gained from the small sample is also a starting point from which can be built upon it is hoped, as a means of providing signposting within an area of unmet need. It was also of some regret that none of the referring clinicians were Community Paediatricians. This may have reflected the structure of the multi-disciplinary paediatric service assessing under-fives. Further research would be needed to build on the findings from this study.

Second, the original aim for the study was to work in a collaborative manner with paediatrics regarding the referred children, as well as to foster an environment in which psychoanalytic thinking could have a presence within the paediatric service. It was envisaged that this may be possible through informal discussions about psychoanalytic thinking and perspectives upon the work being undertaken. Unfortunately, obstacles to this vision limited the ability to fully realise these professional links. The division of services into differing Trusts, commissioning groups and buildings did not foster an approach in which clinicians from similar but separate services could work together without consideration of service level agreements, room space and insurance being experienced.

Third, as previously outlined above, the impact of the COVID-19 pandemic was unforeseen during the planning and preparation of this research study. Despite the difficulties of transitioning to online clinical work and research, the outcomes of the brief intervention and the contribution for referrer’s continued to be positive. However, additional time was needed due to these changes to transfer the intervention to online sessions which resulted in two of the families receiving more than the originally intended five clinical sessions. The research was also originally conceived at a time when I was completing my clinical training, however due to significant delays in securing the necessary ethical approvals, I was then in a clinical lead role with significantly less time available during my clinical week when the research study began. Research interviews were also conducted online and the possible benefits and impact on these have been noted in the Research Design & Methodology chapter.

Finally, the parameters of this study were restricted due to the time permitted to complete. Within the initial design of the study, a follow up questionnaire was intended to be administered to the research participants. It was hoped that this part of the research design would have evidenced a process of learning for the referring community paediatric clinicians. As it was, only one child in the intervention cohort remained open to the paediatric service for further review after referral to the brief intervention. This would have limited the ability to undertake such a follow up interview. Further research that could consider the development of an under-fives intervention in this way could provide additional learning regarding how the intervention was perceived and used by our paediatric colleagues.

Conclusion

To conclude, my hope for this research study was to provide and research a brief parent-child intervention that positively contributed to the paediatric diagnostic assessment of the referred child. Despite some of the physical limitations, as well as the dramatic changes that both CAMHS and paediatric services were required to undertake during the COVID-19 pandemic, the research was able to fulfil its' goal of researching the experiences of the contribution of the intervention for the referring paediatric clinicians. All the participants, both referrers and parents, experienced a positive contribution from the intervention.

There was a significant lack of research and literature that identified how the delivery of a Child Psychotherapy intervention may impact upon the assessment or treatment decisions made by other clinical professions. In fact, there were only a small number of studies in mental health research that considered the perspective of the referring clinician. This research study contributed to the field of Child Psychotherapy research by evidencing the positive contribution that a brief intervention could provide to both families and paediatric services.

I hope that this study could spark an interest in further research to consider this little known area of clinical collaboration to further strengthen the role of Child Psychotherapy in supporting our paediatric colleagues, as well as young children and their families.

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8 Appendices

8.1 NREC approval letter

Ymchwil Iechyd
a Gofal Cymru
Health and Care
Research Wales

NHS
Health Research
Authority

Mrs Elizabeth Stockwell

Email: hra.approval@nhs.net
HCRW.approvals@wales.nhs.uk

11 November 2019

Dear Mrs Stockwell

HRA and Health and Care Research Wales (HCRW) Approval Letter

Study title:	**Child Psychotherapy in a Paediatric Out-Patient Setting: How can a Brief Intervention Service contribute to the assessment of Under 5's?**
IRAS project ID:	**238801**
Protocol number:	**N/A**
REC reference:	**19/LO/0873**
Sponsor	**University of East London (UEL)**

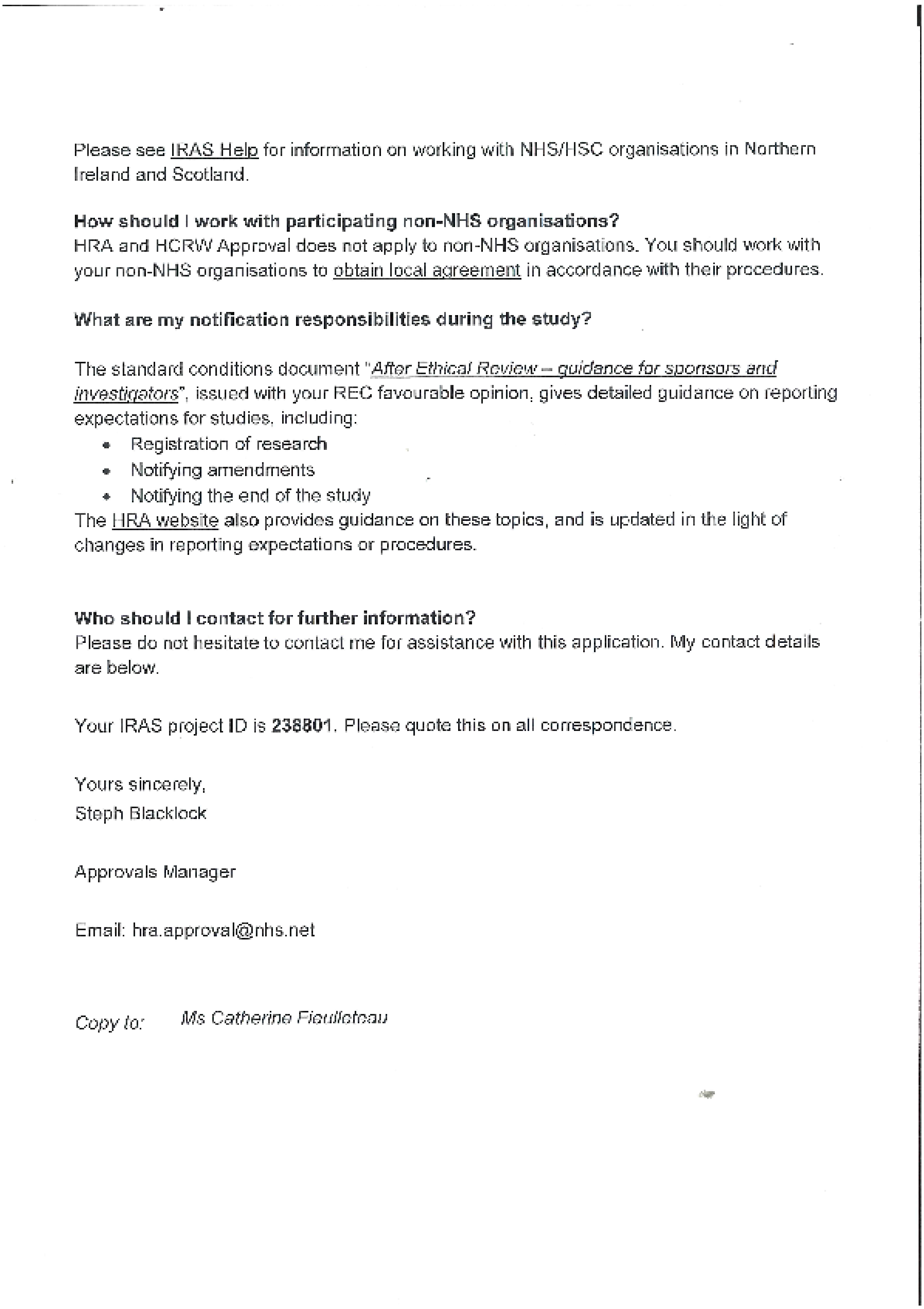
I am pleased to confirm that **HRA and Health and Care Research Wales (HCRW) Approval** has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications received. You should not expect to receive anything further relating to this application.

Please now work with participating NHS organisations to confirm capacity and capability, in line with the instructions provided in the "Information to support study set up" section towards the end of this letter.

How should I work with participating NHS/HSC organisations in Northern Ireland and Scotland?

HRA and HCRW Approval does not apply to NHS/HSC organisations within Northern Ireland and Scotland.

If you indicated in your IRAS form that you do have participating organisations in either of these devolved administrations, the final document set and the study wide governance report (including this letter) have been sent to the coordinating centre of each participating nation. The relevant national coordinating function/s will contact you as appropriate.



Please see IRAS Help for information on working with NHS/HSC organisations in Northern Ireland and Scotland.

How should I work with participating non-NHS organisations?
HRA and HCRW Approval does not apply to non-NHS organisations. You should work with your non-NHS organisations to obtain local agreement in accordance with their procedures.

What are my notification responsibilities during the study?

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

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

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

Who should I contact for further information?
Please do not hesitate to contact me for assistance with this application. My contact details are below.

Your IRAS project ID is **238801**. Please quote this on all correspondence.

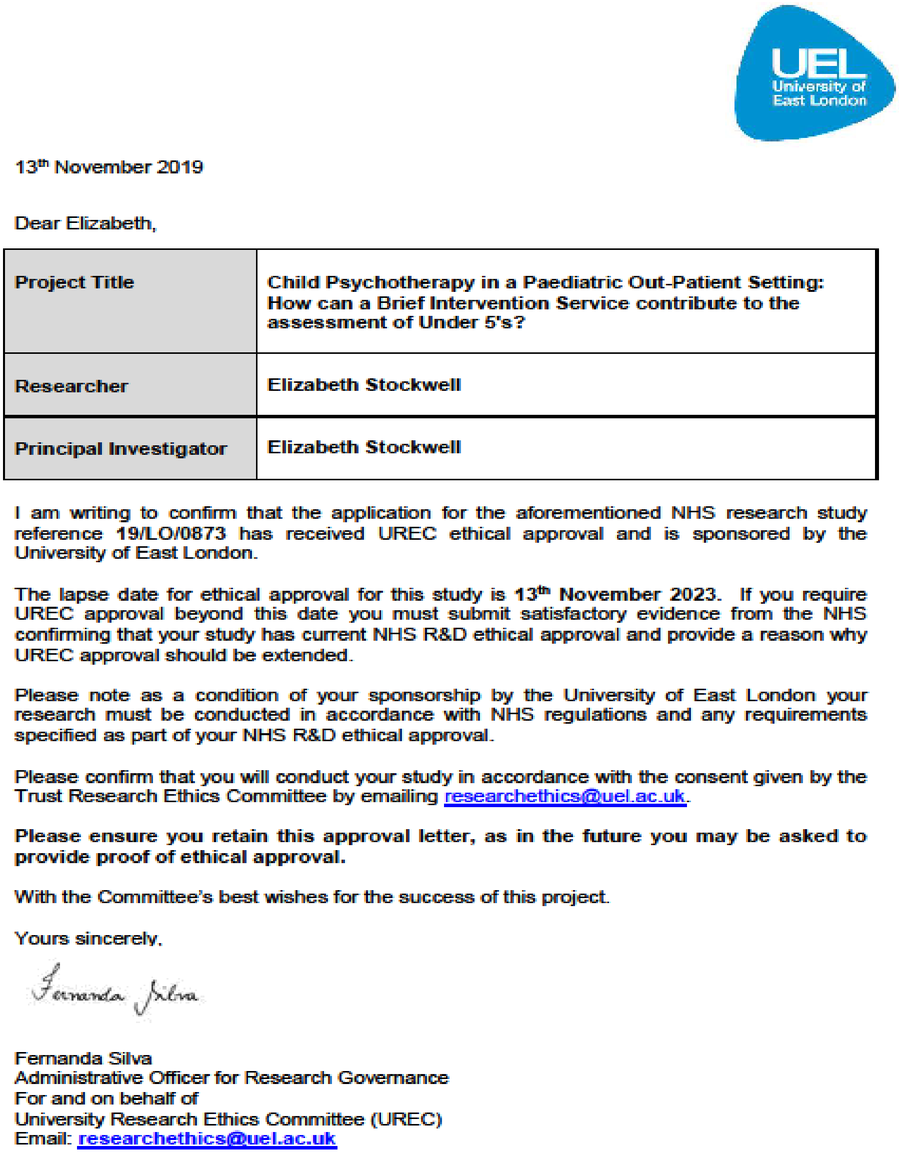
Yours sincerely,
Steph Blacklock

Approvals Manager

Email: hra.approval@nhs.net

Copy to: *Ms Catherine Fieulleteau*

8.2 UREC approval letter



UEL
University of
East London

13th November 2019

Dear Elizabeth,

Project Title	**Child Psychotherapy in a Paediatric Out-Patient Setting: How can a Brief Intervention Service contribute to the assessment of Under 5's?**
Researcher	**Elizabeth Stockwell**
Principal Investigator	**Elizabeth Stockwell**

I am writing to confirm that the application for the aforementioned NHS research study reference **19/LO/0873** has received UREC ethical approval and is sponsored by the University of East London.

The lapse date for ethical approval for this study is **13th November 2023**. If you require UREC approval beyond this date you must submit satisfactory evidence from the NHS confirming that your study has current NHS R&D ethical approval and provide a reason why UREC approval should be extended.

Please note as a condition of your sponsorship by the University of East London your research must be conducted in accordance with NHS regulations and any requirements specified as part of your NHS R&D ethical approval.

Please confirm that you will conduct your study in accordance with the consent given by the Trust Research Ethics Committee by emailing researchethics@uel.ac.uk.

Please ensure you retain this approval letter, as in the future you may be asked to provide proof of ethical approval.

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

Yours sincerely,

Fernanda Silva

Fernanda Silva
Administrative Officer for Research Governance
For and on behalf of
University Research Ethics Committee (UREC)
Email: **researchethics@uel.ac.uk**

8.3 Primary Parent information sheet

Primary Parent Information Sheet

Child Psychotherapy in a Paediatric Outpatient Setting: How can a Brief Intervention Service Contribute to the Assessment of Under 5’s?

My name is Liz Stockwell and I am a Child & Adolescent Psychotherapist studying for a Professional Doctorate in Child & Adolescent Psychotherapy at the University of East London (UEL) and the Tavistock & Portman NHS Foundation Trust. I am the Chief Investigator for the research study. I hold a current Disclosure and Barring (DBS) certificate.

I would like to invite you and your child to take part in a research study evaluating a brief child psychotherapy intervention for children aged five and under. Before you decide, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information to help you decide whether or not you wish for information about your child and their participation in the brief intervention to be included in the research study.

The Tavistock and Portman NHS Foundation Trust is the sponsor for this study based in the United Kingdom. I will be using information regarding your child in order to undertake this study and will act as the data controller for this study. This means that I am responsible for looking after their information and using it properly. I will keep identifiable information about your child from this study for no more than three months after the study has finished.

Your rights to access, change or move your child’s information are limited, as I need to manage this information in specific ways in order for the research to be reliable and accurate. To safeguard your child’s rights, I will use the minimum personally identifiable information possible. I will use your child’s name and the contact details you provide only to contact you about the research study. I am the only person who will have access to information that identifies your child. I may be assisted in the analysis of this information by senior colleagues, but they will not be able to identify you and will not be able to find out your child’s name or contact details.

You can find out more about the legal framework within which your child's information will be processed by contacting the sponsoring Trust's Clinical Governance and Quality Manager, Irene Henderson: IHenderson@tavi-port.nhs.uk

[redacted] will use your child's name, NHS number and contact details to contact you about the research study, and make sure that relevant information about the study is recorded for your child's care, and to oversee the quality of the study. Individuals from [redacted] and regulatory organisations may look at your child's medical and research records to check the accuracy of the research study. [redacted] will pass these details to the Tavistock and Portman NHS Foundation Trust along with the information collected from you and your child's medical records. The only people in The Tavistock & Portman NHS Foundation Trust who will have access to information that identifies your child will be people who need to contact you to audit the data collection process. The people who analyse the information will not be able to identify your child and will not be able to find out your child's name, NHS number or contact details.

[redacted] will keep identifiable information about your child from this study for ten years after the study has finished.

What is this study about?

The aim of the research study is to evaluate the contribution that a brief child psychotherapy intervention may make towards the assessment of children aged five and under who are currently being assessed or reviewed by a Community Paediatrician.

Your child's Community Paediatrician has made a referral for a brief child psychotherapy intervention to be offered to you and your child. The purpose of the intervention will be to think together about what your child's behaviour and current difficulties are and try to understand what emotions this behaviour may be expressing. At the first appointment, you will be asked to complete two short routine questionnaires which are given to all parents of children referred to the intervention. These questionnaires will ask for your views regarding your child's difficulties, as well as identifying the goals that you would hope to be achieved by the intervention.

Up to five appointments will be offered to you and your child to enable us to think about and discuss your child's current difficulties and developmental history. Clinical observation of your child within the appointments, with the aim of understanding what emotions this behaviour may be communicating, will form a large part of the clinical work being undertaken.

At the last appointment, you will also be asked to complete two further routine short written questionnaires regarding your view of your child's difficulties and whether you feel the goals identified at the start of the intervention have been met. You will also be asked your views regarding the brief intervention itself.

Following completion of up to five appointments, you will be provided with a written report detailing the work undertaken, a clinical opinion regarding your child's difficulties and any recommendations for support or future therapeutic treatment. Your child's referring Community Paediatrician and their GP will be provided with a copy of this report also.

The referring Community Paediatrician will then be invited to undertake a semi-structured interview with me to find out their views of the brief intervention and what they feel the possible contribution of the intervention may have contributed to their assessment of your child, and future children that they assess.

If you child is reviewed at a later date by their Community Paediatrician, usually six to twelve months later, the Community Paediatrician will be invited to undertake a second semi-structured interview to evaluate the possible contribution of the brief intervention at this reviewing stage in your child's treatment.

Is my child eligible to take part?

The requirements for information regarding your child to be included in the research are:

- Your child has been referred by Community Paediatrics for a brief child psychotherapy intervention.
- Your child is aged five of under at the time of the referral.
- You hold parental responsibility for your child in order to consent to information about your child being included within the research study.
- Your child does not already have a developmental diagnosis e.g. Autistic Spectrum Disorder (ASD)

Does my child have to take part?

It is up to you to decide whether or not you would like information about your child to be included in this research study.

If you decide not to take part, this will not affect the treatment that will be offered to your child and the brief child psychotherapy intervention will still be offered in the usual way.

If you decide to take part, you will be asked to sign a consent form. Your consent is being requested to provide agreement for anonymised data regarding your child's gender, age, presenting difficulties and anonymised clinical process notes from the appointments that you and your child to attend to be included within this research project. You will be free to withdraw without giving a reason and without this affecting the intervention being offered. A letter will be sent to your child's GP informing them that you have consented for data regarding your child to be included within this research project. You will be provided with a copy of this letter.

What would taking part involve?

The brief intervention Child Psychotherapy involves you and your child attending up to five appointments with a Child & Adolescent Psychotherapist. Each appointment will last up to fifty minutes in duration. At the first appointment, you will be asked to complete two routine questionnaires. At the final appointment, you will be asked to complete two routine review questionnaires. You will also be invited to complete an 'Experience of Service' questionnaire.

Agreeing to anonymised information about your child to be included in this research project would not involve anything additional to you and your child, other than completing the attached consent form.

What are the advantages and disadvantages of taking part in this research?

By agreeing to anonymised information about your child to be included in his research, you and your child will be contributing to an evaluation of an intervention that may benefit children who are experiencing behavioural or emotional difficulties. It is hoped that this research will enable health professionals to work towards identifying which services and interventions can help children overcome or alleviate their difficulties whilst still in early childhood.

Attending up to five clinical appointments will involve you talking and reflecting upon the nature of your child's current difficulties and how this might be impacting upon them, their development and your family. Talking and reflecting on these feelings and experiences can be helpful, although it can also sometimes feel difficult.

Confidentiality

All information collected regarding your child attend the appointments attended will be kept strictly confidential and stored securely as per NHS guidelines. Only the other members of the research team who have been named above and the regulatory authorities will have access to information gathered through the study. The study will comply with Data Protection laws.

At the end of the research study, the information gathered as part of the research study would be written up and anonymised using pseudonyms. The written findings would then be shared with [redacted], the Tavistock & Portman NHS Trust and the University of East London. Within this information, anonymised direct quotes may be used in published and unpublished form such as publications, reports, web pages, conference papers and other research outputs. As a research participant, you will receive a written summary of the research findings at the end of the research study.

Who has reviewed the study?

The study has been reviewed and approved by the London-Camden & Kings Cross Research Ethics Committee and the Health Research Authority.

Next steps

If you are interested in your child's information being included in this research study, please complete the consent questions on the next page.

If you would like any further information about this study, please contact Liz Stockwell by email at elizabeth.stockwell@nhs.net

If you have any complaints about the research, please contact: Ms Catherine Fieulleteau – UEL Ethics Integrity Manager Address: University of East London, Graduate School, Docklands Campus, Room EB 1.43, London, E16 2RD Email: Research.Ethics@UEL.ac.uk Tel no: 0208 223 668

8.4 Primary Parent consent form

Primary Parent Consent Form

Child Psychotherapy in a Paediatric Outpatient Setting:
How can a brief Intervention service contribute to the assessment of under-fives?

Please tick to confirm your consent:

I confirm that I have read and understood the ‘Primary Parent Information Sheet’ relating to the above programme of research. The nature and purposes of the research have been explained to me, and I have had the opportunity to discuss the details and ask questions about this information. I understand what is being proposed and the procedures in which my child and I will be involved have been explained to me. ☐

I have been given a copy of the Primary Parent Information Sheet and Consent Form to keep. ☐

I understand that anonymised information about my child will be included in this research study. ☐

I confirm that I give my consent for my child’s GP to be notified in writing of my child’s participation in this research study. ☐

I understand that involvement in this study, and in particular data from this research, will remain strictly confidential. Only the researchers involved in the study will have access to the data. ☐

It has been explained to me what will happen once the research has been completed. ☐

I hereby freely and fully consent for data regarding the child named below to be included in this research and for the information obtained to be used in relevant research publications. ☐

Having given this consent, I understand that I have the right to withdraw from the study at any time prior to data analysis without disadvantage to my child's routine treatment and without being obliged to give any reason. ☐

Primary Parent's Name (BLOCKCAPITALS)………………………………………………… on
behalf of………………………………………………………………………………Child's name

Primary Parent's signature…………………………………………………………………

Chief Investigator's Name (BLOCK CAPITALS)…………………………………………………
Investigator's Signature………………………………………………………………………..
Date…………………………………………………………………………………………

8.5 Clinician Information Sheet

Clinician Information Sheet

Child Psychotherapy in a Paediatric Outpatient Setting:
How can a brief Intervention service contribute to the assessment of under-fives?

My name is Liz Stockwell and I am a Child & Adolescent Psychotherapist studying for a Professional Doctorate in Child & Adolescent Psychotherapy at the University of East London (UEL) and the Tavistock & Portman NHS Foundation Trust. I am the Chief Investigator for the research study. I hold a current Disclosure and Barring (DBS) certificate.

This research study is sponsored by UEL. The Director of Studies is Dr Jenifer Wakelyn, Child & Adolescent Psychotherapist at the Tavistock & Portman NHS Foundation Trust.

I would like to invite you to take part in a research study evaluating a brief Child Psychotherapy intervention for children aged five and under. Before you decide, it is important for you to understand why the research is being undertaken and what it will involve. Please take time to read the following information to help you decide whether or not you wish to participate in the research study.

What is this study about?

The aim of the research study is to evaluate the contribution that a routine brief Child Psychotherapy intervention may make towards the paediatric assessment of children aged five and under who are currently being assessed or reviewed by a Community Paediatrician.

The study will focus upon children who are aged five or under and are experiencing emotional and/or behavioural difficulties and are referred by you for a routine brief Child Psychotherapy intervention. Following referral, the child and their Primary Parent/s will be offered up to five appointments. During these routine appointments, the Primary Parent, together with the Child Psychotherapist, will be asked to think about the child's current difficulties and early developmental history. Clinical observation of the child within the sessions, with the aim of understanding what emotions their observed behaviour may be communicating, will form a large part of the clinical work being undertaken.

Following the completion of up to five appointments, a written report detailing the work undertaken, a formulation regarding the child's difficulties and any recommendations for support or future intervention will be shared with the Primary Parent, you as the referring Community Paediatrician and the child's GP.

As the referring Community Paediatrician, you will then be invited to participate in a semi-structured interview for this research study. The aim of the interview will be to find out your views of the routine brief Child Psychotherapy intervention and what you feel the possible contribution of the intervention may be to the paediatric assessment of the referred child, and any future children that you may assess.

If the referred child is reviewed at a later date, for example six to twelve months later, you will be invited to participate in a second semi-structured interview to evaluate the possible contribution of the routine brief intervention at this reviewing stage of the child's treatment.

Who is eligible to take part?

Community Paediatricians who have referred a child aged five and under to receive a routine brief Child Psychotherapy intervention, and who's Primary Parent has consented to their child's data being included within the research, will be invited to participate in up to two semi-structured interviews following completion of the routine brief intervention.

Do I have to take part in this study?

It is up to you to decide whether you would like to participate in this research by providing your views within a semi-structured interview.

If you decide that you do not wish to participate, this will not affect the routine intervention that will be offered to the referred child which will be offered in the usual way.

If you decide to take part, you will be asked to complete a written consent form. You will be free to withdraw at any time prior to data analysis without giving reason and without this affecting the routine treatment being offered to the referred child.

What would taking part involve?

Taking part in the research would involve participating in up to two semi-structured interviews regarding your experience of the contribution of the brief child psychotherapy intervention to your paediatric assessment of the referred child. It is anticipated that these interviews will last approximately one hour each and will be arranged at a convenient date and location for you. To enable full transcription of the interview, audio recording equipment would be used.

What are the advantages and disadvantages of taking part in this research?

By participating in this research, you will be contributing to an evaluation of an intervention that may benefit children who are experiencing behavioural or emotional difficulties. It is hoped that this research will enable health professionals to continue to work towards identifying which services and interventions can help children overcome or alleviate their difficulties whilst still in early childhood.

Participating in the research would involve a time commitment of up to two 1-hour interviews to provide your views regarding the possible contribution of the intervention.

Confidentiality

All information collected regarding the referred child and semi-structured interview data will be kept strictly confidential and stored securely as per NHS guidelines. Only the other members of the research team who have been named above and regulatory authorities will have access to information gathered through the study. The study will comply with Data Protection laws.

At the end of the research study, the information gathered as part of the research study will be written up and anonymised using pseudonyms. The written findings would then be shared with [redacted], the Tavistock & Portman NHS Trust and the University of

East London. Within this information, anonymised direct quotes may be used in published and unpublished form such as publications, reports, web pages, conference papers and other research outputs. As a research participant, you will receive a written summary of the research findings at the end of the research study.

Who has reviewed the study?

The study has been reviewed and approved by the London – Camden & Kings Cross Research Ethics Committee and the Health Research Authority.

Next steps

If you are interested in participating in this research study, please complete the consent questions on the next page.

If you would like any further information about this study, please contact Liz Stockwell by email at elizabeth.stockwell@[redacted]nhs.uk

If you have any complaints about the research, please contact:

Ms Catherine Fieulleteau – UEL Ethics Integrity Manager

Address: University of East London,

Graduate School,

Docklands Campus,

Room EB 1.43,

London,

E16 2RD

Email: Research.Ethics@UEL.ac.uk

Tel no: 0208 223 6683

8.6 Clinician consent form

Clinician Consent Form

Child Psychotherapy in a Paediatric Outpatient Setting:
How can a Brief Intervention contribute to the assessment of under-fives?

Please tick to confirm your consent:

I confirm that I have read and understood the ‘Clinician Information Sheet’ relating to the above programme of research. The nature and purposes of the research have been explained to me, and I have had the opportunity to discuss the details and ask questions about this information. I understand what is being proposed and the procedures in which I will be involved have been explained to me. ☐

I have been given a copy of the Clinician Information Sheet and Clinician Consent Form to keep. ☐

I understand that I am agreeing to participate in up to two semi-structured interviews lasting approximately one hour each and that these interviews will be audio recorded for the purposes of transcription. ☐

I understand that anonymised data from the semi-structured interview/s will be included in the research study. ☐

I understand that my involvement in this study, and in particular data from this research, will remain strictly confidential. Only the researchers involved in the study will have access to the data. ☐

It has been explained to me what will happen once the research has been completed. ☐

I hereby freely and fully consent for my semi-structured interview data to be included in this research and for the information obtained to be used in relevant research publications. ☐

Having given this consent, I understand that I have the right to withdraw from the study at any time up until data analysis without being obliged to give any reason. ☐

Clinician’s Name (BLOCK CAPITALS)…………………………………………………………

Clinician’s signature……………………………………………………………………………

Chief Investigator’s Name (BLOCK CAPITALS) ………………………………………………..

Chief Investigator’s Signature……………………………………………………………………………

Date……………………………………………………………………………………………..

8.7 Semi-structured interview schedule

Semi-structured interview for Community Paediatrician

Child Psychotherapy in a Paediatric Outpatient Setting: How can a brief Intervention service contribute to the assessment of under fives?

Prior awareness of Child Psychotherapy and the brief intervention

- When did you begin to work as a Community Paediatrician?

- Prior to referring Child X to the service, have you had experience of working with Child and Adolescent Psychotherapists?

If yes, could you outline the nature of this?

- Prior to referring Child X, were you aware of the brief intervention that Child Psychotherapists are offering to children aged under 5?

- Have you previously referred a child to the intervention?

If yes, how many prior to this current referral?

Process of referring children to the brief intervention

- Were you present at the Community Paediatrician's meeting held on [redacted] during which the under 5's brief intervention psychotherapy service was outlined?

- If yes, did this influence your decision to refer Child X to the intervention?

- What were your hopes for the outcome of the intervention for Child X?

- A report outlining the intervention undertaken, a formulation of Child X's difficulties and recommendations for future support has been provided following the intervention. Did you find this letter contributed to your overall assessment of Child X?

- If yes, in what ways?

- If no, why not?

- Where would you see the value, if any, of a brief intervention for children aged under 5?
    - Where in the process would it be most valuable? (e.g. prior to any diagnosis; after a diagnosis; after the initial CP review; or after subsequent reviews)
    - For which presenting difficulties/symptoms would you feel this intervention would be most valuable?
    - If you don't feel that this intervention adds any value to the paediatric assessment process, why not?

Review

- How do you think that the intervention and subsequent formulation might impact upon your next paediatric review of Child X?
- What do you understand will be the next treatment steps for Child X?
- Has the brief intervention influenced this treatment plan in any way?
- Would you be happy to complete a follow-up questionnaire regarding Child X's progress following their next Paediatric review in 6-12 months' time?

Impact of Brief Intervention Service

- Based on your current experience of the service, would you consider referring further children to the intervention?
- Why?

- How do you think your experience of the intervention might impact upon your continuing work with other children you are working with who have not been referred to the intervention?

- Would you recommend this service to?
  - Primary parents and carers
  - Other Community Paediatricians
  - Other health colleagues

8.8 Clinical Formulation reports

Clinical Formulation report “Archie”

Dear referrer,

Re: “Archie”

Thank you for referring 5 year old Archie to the ‘Under 5’s brief parent-child psychotherapy intervention’. As you know, this intervention is currently the focus of a research study aimed at providing between 5 to 10 psychoanalytic sessions using clinical observation and interpretation to gain a greater understanding of a child’s behaviour and communication. The focus of the research is to see how an interdisciplinary approach can help young children and their parents where desired progress has not yet been achieved and additional thinking and support between paediatrics and mental health services is needed.

We are pleased to say that following your referral, Archie’s parents have provided their written consent for Archie to be included within the research project as he met the inclusion criteria. This included prior assessment and support from Paediatric Services, which for Archie included support from Occupational Health, Physiotherapy, Speech and Language Therapy and specialist behavioural input. The research study is also aimed at supporting children aged under 5 at the time of the referral, who have not been diagnosed with a neuro-developmental disorder. Archie had been assessed within the paediatric diagnostic pathway and had been diagnosed with anxious behaviours impacting upon his daily life, a phonological sound disorder and mild sensory processing difficulties. Although Archie has received support from a number of clinical interventions, he continued to experience areas of difficulty that impacted upon him and his family life. We welcomed the opportunity to think further with you and Archie’s parents about Archie’s emotional needs and contribute to the overall assessment of Archie’s needs.

To participate within the research study, parents and their child attend at least three clinical sessions. Archie and his parents have now attended eight clinical sessions. The first two sessions were in person. Due to COVID-19 restrictions introduced, changes to the provision of the clinical intervention were required. This has had a clear impact upon the ability of clinical observation of the play and interactions of Archie within a clinical setting, however although there are some technological limitations, the emotional and behavioural needs of Archie and a thinking space for his parents to consider this within a clinical framework has continued to be available. Archie and his parents have been supported through six online sessions. A transition planning meeting with Archie's new primary school was also held and a review school meeting also held. Having completed eight sessions, it was felt this would be a helpful time to feedback our observations and clinical formulation regarding Archie to you, Archie's parents and his GP and we welcome further thinking with you about Archie's progress.

Clinical Formulation

At the time of your referral Archie had been experiencing a range of difficulties for over a year. Through information provided within your referral, and information gathered within the clinical sessions, the focus of the [redacted] brief parent-child psychotherapy intervention has focused upon three main areas of difficulty – anxieties and rigidities; transitions and toileting.

Anxiety & rigidities

Archie experiences higher levels of anxiety in certain situations outlined in your referral that caused him to experience some distress within everyday situations. He could respond with regressed speech and behaviour and crying to communicate how he felt scared in these situations.

Clinical observation of a child's play is central to Child Psychotherapy. Within Archie's play, themes of safety were dominant, and he was sensitive to a possible threat to the safety he wished to maintain. This was observed when Archie interacted with a crocodile in the clinical room over the course of the intervention. In sessions, Archie assumed the role of providing safety to others by containing any danger the crocodile might pose by building fences and checking with his parents whether the structures he built were robust enough. In between sessions, Archie asked his parents about the crocodile, and it was evident that his view of how safe his world was around him was impacting upon how anxious he was at times. Archie's start to life was itself an anxious time for the family, due to the sickness that his mother felt during the pregnancy, the alarming breaking of her waters at 20 weeks and the long labour that required emergency medical intervention immediately following Archie's birth. When thinking about the experience of Archie's birth with the family, Archie was observed to build a fire engine from items in the room, as though he had an awareness of the mechanisms that could re-instate safety within a situation of danger. Archie was also observed to lie across his mother's knee, as if he were sensitively aware of the concern and anxiety that the account provoked.

To help manage Archie’s anxiety he has developed certain rigidities around transitions, sleeping and eating. Such ways of ordering his environment enable Archie to provide a predictable and controlled approach to his environment as a means of reducing any anxiety that might be provoked by uncertainty. Within the eight sessions offered so far, we and Archie’s parents have seen gradual improvements in Archie’s levels of anxiety and his ability to manage this. Although Archie continues to require additional support at times to help him to manage his anxiety, his parents have observed an easing of his worry about leaving the family home, communicating with others outside his immediate family and he is beginning to show less distress in situations which previously caused him great alarm. We have observed Archie to grow in confidence, communication and humour throughout the sessions he has attended.

Transitions

At the time of your referral, Archie liked to stay at home. His parents were finding it hard to encourage Archie out of bed in the morning and he was also resistant to getting dressed. At times, he liked to be wrapped in a blanket. He also found the transition from one season’s clothes to another difficult. However, Archie had successfully managed the transition into nursery school. He has enjoyed aspects of learning and likes solving problems and puzzles. He managed the experience of nursery education through the support of visual aids and ‘now and next’ methods to organise his activities.

One of the main areas of focus of the intervention offered has been to think about Archie’s transition from nursery to primary school. His parents had a number of concerns prior to this transition and had made enquiries about Archie being assessed for an Educational Health Care Plan (EHCP) to ensure that he would be adequately supported. At that time, multi-agency enquiries that took place did not reach all of the professional agencies working with Archie and a decision was reached that an EHCP assessment would not be recommended. However, this enabled Archie’s parents to have additional time to discuss their concerns further with Archie’s nursery, new primary school and CAMHS and it was agreed that further monitoring of Archie within his new school would be beneficial prior to a decision on this matter being taken.

Within clinical sessions, we have thought about how Archie could be supported to prepare for primary school, by returning to his nursery school during lockdown restrictions for a short period of time just before the end of the summer term. Such transitions are vital for young children to be able to experience successfully completing a stage of their education, saying goodbye, and moving onto the next stage of the school career. Archie managed this return well and we feel this was a significant factor in supporting him to transition into a new phase of his education.

Prior to the transition to primary school, we facilitated a transition meeting attended by Archie's parents, Nursery and Primary school. This gave Archie's parents the opportunity to discuss their concerns, and what worked well in supporting Archie. We also considered how he could be supported to adapt to a school environment where there may be less support around aspects of care, such as toileting and getting dressed. Following Archie starting primary school, a further meeting was arranged to think about his progress and any areas of continuing concern. It was very pleasing to hear that Archie had experienced a very positive start to his school career. He was happy to attend school and rarely verbalised negative comments about it. His parents used a visual plan which helped Archie to get himself dressed and be ready for his school day. Once at school, Archie is keen to learn and has a strong motivation to 'better himself'. He has favourite activities that centre on construction toys and the water table and needs encouragement to try new activities which would expand his learning and the peer group that he played with. Primary School had supported Archie with some initial strategies so that he knew where to sit at carpet time and could engage with fifteen-minute activities with the rest of the class. He was also supported to use the school toilets by being reminded three times per day by his teacher. Archie has also been receiving speech and language support in school and is due to begin small group support, alongside continued individual support, to continue to build upon the improvements he has demonstrated. It was positive to hear that teaching staff felt that Archie could thrive within mainstream education without the need for additional support, such as an EHCP.

Toileting

The final area of focus within clinical sessions has been in relation to Archie's toileting. Archie was initially toilet trained when he was three years old. However, around eight months later Archie's progress had regressed, and he was having frequent accidents. The timing of this appeared to have some link with an extended family holiday in which Archie experienced being in unfamiliar surroundings. His parents recalled a particular difficult memory where the extended family commented on Archie having an accident in the lounge. Archie continued to have accidents up to two-three times per day following this.

Archie's parents have expressed that they feel that Archie does not wish to recognise the need to use the toilet even though he is able to recognise the physical sensations. When they see the signals and remind him, he refuses to comply with their request and at times can be verbally aggressive. During clinical sessions, the feeling of pressure for Archie to master this skill prior to the start of primary school had begun to concern his parents. Although Archie had made progress in passing urine in the toilet, he continued to regularly soil himself at home while continuing to play on all fours. During clinical sessions, we thought with Archie's parents about how they can step back from encouraging Archie to use the toilet, which is often met by stubborn refusal, and to harness Archie's developing ego strength and increasing desire to be in control, as a means of him successfully mastering this aspect of development. The use of a visual aid, which was working well in the morning, has been incorporated into the return home from school. Recent sessions with Archie have also thought about his expressed wish to retain his faeces within him, and a dialogue has been opened up between clinical sessions in which Archie expressed some of his anxiety about feeling he may be listened to when using the toilet which may have inhibited him at times.

Archie is currently making some progress to use the toilet to both pass urine and faeces. Archie's parents continue to support him at home with the use of visual aids, which he gradually needs to rely on less. Archie continues to communicate with his parents regarding his preferences that can help him to successfully use the toilet himself, and to work towards him using the toilet without the need for parental intervention.

Archie's experience of parental and professional support

Throughout the intervention offered, Archie's parents' sensitive and thoughtful approach to thinking about Archie's difficulties and reflect on their individual responses to this has been a significant reason why we feel Archie has progressed in his current development. Both parents have prioritised attending appointments and have been open to accessing whatever support is offered to them to achieve the best outcome for Archie. The role of fathers in parent-child psychotherapy is vital in acknowledging a child's need for a maternal and paternal parenting function, however often due to modern day circumstances and the commitment to work, the ability to have both parents present within therapeutic work can be limited.

Archie's experience of having intuitive parents has been echoed within his nursery school experience and he has benefitted from the support of his Key Worker at nursery, who often responded to Archie's nonverbal cues to support him in his nursery activities. Now as Archie transitions into a busier environment within school, he is beginning to develop the skill of needing to reach out verbally to enable others to assist him which at times will be challenging for Archie as he is partly used to other responding intuitively, as well as his wish to be more grown up, without always recognising that we all require the support of others at times.

Recommendations

A recent review of Archie's progress has noted improvements in aspects of daily life that had been causing Archie immense worry and fear. A review 'Strength and Difficulty' questionnaire has highlighted a reduction in the spheres of 'emotional, conduct, hyperactivity and peer relationship' difficulties and an increase in 'pro-social' behaviours. Archie's mother feels the brief parent-child intervention has helped Archie and them to make positive progress in the three areas of focus for the intervention.

As toileting continues to be an area that still requires some additional thinking and support in conjunction with some new approaches being adopted at home and school, we therefore will continue to work with Archie, his parents and school to hopefully begin to make further progress in this area soon. At present, due to the national lockdown some of the implementation of these approaches has not been fully possible.

We will write again to share further thoughts with you when the brief parent-child intervention has been completed.

Yours sincerely,

Chief Investigator

Clinical Formulation report of “Bonnie”

Dear referrer,

Re: “Bonnie”

Thank you for referring 5 year old Bonnie to the ‘Under 5’s brief parent-child psychotherapy intervention’. Your referral came at a time when a research study which I am leading is being undertaken. We are hoping to explore whether a brief specialist CAMHS intervention would be helpful where desired progress for a young child had got stuck in some way and a joint paediatric and CAMHS approach could provide additional thinking and support to the referred child and their parents. We are pleased to say that following your referral, Bonnie’s parents, consented to Bonnie being included within the study.

Bonnie had been experiencing a range of difficulties since eighteen months of age. Although Bonnie has been provided with a foundation of support from Paediatrics, Bonnie’s parents continued to experience difficulties regarding Bonnie’s anxieties and behaviour, within the context of attachment difficulties identified by Paediatrics. We welcomed your referral to think further with you and Bonnie’s parents about her emotional needs and contribute to the overall assessment of Bonnie.

Clinical Intervention offered

Bonnie and her parents have now attended seven clinical sessions. The first three sessions were in person. Due to COVID-19 restrictions introduced, changes to the provision of the clinical intervention were required.

Regular telephone contact was initially offered, with online sessions being more possible following the return to school in the autumn. Since then, four online sessions have been offered.

In addition, we have liaised with the professional network supporting Bonnie and her family. Social Care was previously involved, and we have participated in a review meeting. A meeting with Bonnie’s primary school was also held.

Early Developmental History

Following a healthy pregnancy, Bonnie was born full term with no difficulties encountered. She was screened and diagnosed with Alpha-1 anti-trypsin deficiency. Bonnie is monitored regularly for this condition. She also has asthma which she manages with an inhaler.

Attachment difficulties were identified by Paediatrics when Bonnie was 3 years old. Attachments are created together by parents and their children through on-going reciprocal relationships. The type of attachment that is created can vary according to the context in which a child is living, the experience of attachments that the child's parents experienced and the child's temperament.

A range of difficulties can be evident for children with attachment difficulties and their parents require additional support to provide the consistent, nurturing, and reciprocal parental relationship that the child requires, without losing hope regarding their abilities to provide this at times. Within the clinical sessions offered, we have also thought with Bonnie's parents about their own experiences of being parented and how this may influence their style of parenting with their own children.

Attachment difficulties have been evident for Bonnie since she was a baby. She demonstrated her need primarily for her mother's care and attention through increased crying, restlessness, and aggression at times when others tried to intervene in her care. Separating at bedtime has been difficult and it has not been possible to establish a routine where Bonnie feels confident to sleep in her own bed.

Bonnie's parents also report fluctuations in Bonnie's moods. At times they describe she is angry and aggressive. She is quick to react to her environment changing and she can respond by being strong-willed. At other times, she communicates her distress by crying and appearing anxious. We have also observed Bonnie to interact positively with her parents in clinical sessions and she enjoys receiving their individual attention, such as listening to her read or watching her draw pictures.

Bonnie's Family History

Bonnie is the youngest child of her parents. She has three elder siblings. To help understand Bonnie's emotional development, it is important to consider the development of her family to understand her place in the family, and the role that Bonnie assumes for herself and others.

Bonnie’s parents met as older teenagers whilst at secondary school. The relationship progressed quickly to living together and their son was born soon after. Due to illness during the pregnancy, Bonnie’s parents took the decision that Bonnie’s mother would cease working and remain at home with their son giving her an experience of time to become a young mother. Their daughter was born two years later, and Bonnie’s parents considered their family to be complete.

When Bonnie’s second sister was born, Bonnie’s mother experienced post-natal depression which unfortunately only became apparent to health professionals after Bonnie’s mother left the family home with her baby daughter and walked around for miles. At that time, Bonnie’s mother felt that she focused all her attention on her daughter, who was experiencing significant physical health difficulties. Bonnie’s mother acknowledged shutting out Bonnie’s father, her son and daughter, who were five and three years old respectively at the time. Bonnie’s mother also felt, like Bonnie currently that her 5 year old daughter could try to assume a parental role within the family which Bonnie’s mother had struggled with.

Bonnie was born seven years later. During Bonnie’s pregnancy there were significant difficulties experienced within the family. Bonnie’s brother who was then aged eleven, reacted aggressively towards the pregnancy. Within clinical sessions Bonnie’s mother shared difficult memories of being pushed by her son in a shop and on another occasion being kicked by him when she was heavily pregnant. Her elder daughter who was nine years old at the time was reported to have positioned herself a Bonnie’s mother’s protector, and at one time attempted to strangle her brother in an attempt to protect her mother. Children can experience their siblings as their rivals for parental attention which they feel is limited and they become focused on the possibility of losing out to their siblings needs. Their emotional response in these situations can be to attack the rivalrous sibling which has been evident within Bonnie’s family. Bonnie too is reported to bite and throws things at her siblings and there have been examples reported that she will attack her siblings if they try and sit near their mother. Bonnie and her eldest sister are also reported to physically fight at times.

Bonnie’s role within the family

We have thought with Bonnie’s parent about how Bonnie often wishes to place herself in a more adult role. Bonnie’s parents gave examples of her chastising her older siblings; taking and hiding her elder sister’s phone and trying to lock the door so that her older brother could not leave the family home. Within clinical sessions we too have seen Bonnie’s wish to assume this grown-up role. She was observed to move around the clinic waiting room confidently and keen to assert her own independence skills in sessions. Although Bonnie appeared confident, she often readily accepts a dummy, possibly highlighting the fragility of her perceived maturity.

During the first clinical session, Bonnie positioned herself very high up on her father's shoulder, stretching up her arm as if to reach the celling. She exclaimed herself as the "boss" of the family when asked by Bonnie's father whose role this was. Conversely over the course of the session, Bonnie's mother positioned herself on the floor after Bonnie continued to make attempts to oust her from the chair she had next to Bonnie's father. Further examples were evident of Bonnie behaving in a manner as if parental boundaries were not present, such as taking her father's car keys and saying she would be the one in the driving seat and going into her mother's bag without permission and retrieving a sandwich to eat in the session. Bonnie was also seen to struggle to accept parental help when she tried to put together her inhaler by herself within the session.

Very young children's attempts to assume parental, pseudo-adult roles can often be met with humour from their family members around them creating a sense in the child that this behaviour is encouraged or permitted in some way. However, the longer-term result of a very young child assuming this role for themselves is experienced when appropriate parental boundaries are attempted to be enforced and as an older child, they continue to place themselves in the parental role, which can feel rivalrous in relation to what the parent is trying to achieve. Young children can also become overwhelmed by the sense of power that they feel they can possess through assuming this role and can feel a sense of relief knowing that a robust parent is present to curtail any brief attempt to inhabit the parental role.

To support Bonnie's parents to feel more as if their parenting of Bonnie is effective, we have thought in sessions about how they can support each other to hold the parental role within the family for all of the children. Paediatrics correctly noted that Bonnie appears more mature than her age and may confuse those around her of her abilities. We have helped Bonnie's parents to think about Bonnie's perceived capabilities and how to develop these in line with expected areas of child development in the context of her attachment difficulties. A combination of Bonnie wishing to assume a more grown-up role within a context of high expectation, can create a situation in which a child begins to push away the need to accept help and can place themselves in more risky situations, due to a lack of understanding about what can be safely achieved.

Bonnie's anxieties

Bonnie transitioned to Primary School at the age of four. She is reported to display little of the behaviours that have concerned her parents at home, and we have spent some time thinking with Bonnie's parents about how this may impact upon how they feel in relation to their parenting of Bonnie.

Bonnie has been described in school reports as sociable and confident once she has become accustomed to people and situations in school. Bonnie also shows high levels of independence at school. This at times is similar to her presentation at home. Bonnie's parents report that Bonnie has difficulty managing the beginnings and ends of the school day, and she can be anxious and reluctant to separate in the morning, coupled with aggression towards them in the evenings.

It is evident that Bonnie is very alert to her surroundings and the communication taking place between her parents and others. When talking with Bonnie's parents about Bonnie's behaviour in school, she was observed with her dummy in her mouth to move towards her mother and place her hand down her mother's top and squeeze her breast then continue on with her activity. Neither parent reacted adversely to this, and Bonnie's mother confirmed that Bonnie often behaved in this way. It may be related to Bonnie's awareness of the nature of the conversation being about her school experiences and seeking out some comfort from her dummy and from Bonnie's mother's breast to hold herself together emotionally. Indeed, in a further session, Bonnie's parents said they felt they were not allowed to speak about school when Bonnie was present. Bonnie then immediately went into Bonnie's mother's handbag and retrieved a sandwich and crisps which she began to eat rather hurriedly filling her mouth.

We have considered examples of how Bonnie provides herself with oral soothing to help manage her emotions. She achieves this in a range of ways such as exploring her world in a bodily way through her mouth by licking and chewing, and through her fingers. She can over fill her mouth and experiences gagging sometimes. She has been observed at home to use self-soothing masturbatory types of behaviour - rubbing her groin against the floor, as well the oral soothing of placing either a dummy or her fingers in her mouth.

Strengthening parental confidence

We have thought about some possible triggers for Bonnie being so unsettled at times and how she continues to try and be in charge of what she eats, when and where she sleeps and what activity she is willing to engage in. She is also drawn to more grown-up activities happening in the family, such as playing on computer games and being in control of the TV.

Very young children who experience big feelings of worry, anger and frustration may prematurely rush to try and feel more mature and omnipotent as a way of managing these very powerful emotions. However, they do not yet have the cognitive and emotional capacities to process these emotions without the support of a parent in tune to this. Bonnie at times wishes to present herself as more able, more independent and rejecting of her parent's attempts to help her at times, therefore giving the impression of a more regulated child than her emotional development has mastered.

In contrast, Bonnie's parents have reflected that the advice and strategies provided to them, rather than feeling helpful, has at times resulted in them feeling de-skilled in their own abilities to know what might work best for Bonnie. This has enabled us to help Bonnie's parents to recognise when they do understand the context in which Bonnie's behaviour arises, and how they in turn can support Bonnie to feel more contained. On occasions when they are able to provide consistent boundaries, they do experience Bonnie's protests. This is when their continued joint parenting role is vital to contain Bonnie's emotional response and help her to move on.

Review of the intervention

Over the course of the intervention, we have observed Bonnie's development. She is now a young girl who continues to display lots of energy and thrives on parental attention at home. She enjoys running, dancing, drawing, and colouring at home. Although her start to school has been significantly disrupted this academic year and last, Bonnie is developing an interest in reading and beginning to form letters and tell stories. Our clinical observations of Bonnie have also noted an increasing maturity. She is more able to participate in clinical sessions, verbally sharing her views more confidently and letting us know if we have got something wrong in our communication with her.

A recent review of Bonnie's progress has noted improvements in some aspects of Bonnie's behaviour. A review 'Strength and Difficulty' questionnaire has highlighted a reduction in the spheres of 'emotional symptoms, hyperactivity/inattention and peer relationship' difficulties. Bonnie's parents also feel that they have got a better understanding of Bonnie's anxieties and behaviours since the start of the intervention.

As the brief parent-child psychotherapy intervention is concluding, we would like to make the following recommendations in relation to further supporting Bonnie and her parents:

- Very young children who are experiencing attachment difficulties often benefit from a child psychotherapy approach in supporting the child and their parents to gain an understanding of the emotional communication underlying worrying behaviour. Given the length of time and range of difficulties that Bonnie has been experiencing, we have recommended an assessment for ongoing child psychotherapy to provide longer term and more regular support to Bonnie and her parents. Bonnie's parents are supportive of this recommendation, and we plan to offer Bonnie an in-person assessment as soon as is possible.

- In the meantime, we will continue to support Bonnie’s parents to continue to build on their awareness that Bonnie is very sensitive to her surroundings and the interactions, emotional availability, and responsiveness of those around her. Bonnie’s parents to continue to be supported to feel empowered to trust their own abilities to provide consistent parenting to Bonnie. This in turn will free Bonnie up to know that her parents will continue to meet her needs, keep her safe and enable her to relinquish some of the pseudo adult control that she feels she needs to assert at home at times.

- We feel that on-going recognition of Bonnie’s age-appropriate abilities needs to continue to be emphasised. Bonnie will then feel confident to assume a more age-appropriate place and enable Bonnie’s parents to continue to be robust in their joint parenting of Bonnie.

- As Bonnie continues to find it hard to sleep within a routine at home, we will be liaising with colleagues in the Paediatric Sleep Pathway to further build on the sleep advice provided by Paediatrics to enable Bonnie’s parents to receive some additional support in this area.

- We also feel that an observation of Bonnie within her school environment, if possible, would also be beneficial in building a picture of Bonnie’s strengths and difficulties.

We welcome further thinking with you about the suggested recommendations and will write again to update you following completion of the Child Psychotherapy assessment sessions.

Yours sincerely,

Chief Investigator

Clinical Formulation report regarding “Carl”

Dear referrer,

Re: “Carl”

Thank you for referring 4-year-old Carl to the ‘Under 5’s brief parent-child psychotherapy intervention’. Your referral came at a time when a research study which I am leading is being undertaken. We are hoping to explore whether a brief specialist CAMHS intervention would be helpful where desired progress for a young child had got stuck in some way and a joint paediatric and CAMHS approach could provide additional thinking and support to the referred child and their parents.

We are pleased to say that following your referral, Carl’s mother, consented for Carl to be included within the project. Although Carl has been provided with a foundation of support from Paediatrics, his aggression and mimicking of animal behaviours was concerning and we welcomed your referral to think further with you and Carl’s mother about his emotional needs and contribute to the overall assessment of Carl.

Clinical intervention offered

Carl is the son of Carl’s mother and father. He has an elder half brother who is ten years old. To date, Carl and his mother have been offered eight sessions and attended five. The first session was attended at the clinic. Due to COVID-19 restrictions introduced, changes to the provision of the clinical intervention were required. This has had a clear impact upon the clinical observation of Carl’s play and interaction, however although there are some technological limitations, the emotional and behavioural needs of Carl and a thinking space facilitated by his mother, within a clinical framework has continued to be available. Four online sessions were also attended. Carl’s mother manages meeting the needs of both of her children alongside a demanding career; at times this has impacted upon her availability to attend appointments, however Carl’s mother has kept in regular contact with us through telephone calls.

Having recently reviewed Carl’s progress, we are able to feedback our clinical formulation regarding Carl to you, his parents and his GP and we welcome further thinking with you about Carl’s progress.

Clinical Formulation

Aggression in response to experiences of frustration

Concern about Carl's aggression was mostly in relation to Carl's attendance at nursery school. He had been observed at times to hurt other children, including biting, throwing objects, and behaving in a noisy and aggressive manner. A decision to move Carl to the nursery, however nursery staff were reported to still be struggling to manage Carl's behaviour and his time at nursery had been reduced.

In the first clinical session, Carl expressed his wish to go home. As we spoke with Carl's mother to conclude the session, Carl was observed to stamp on a toy phone and then press a toy fire engine firmly on one of the clinician's heads. We observed that aggression emerged very quickly in an immediate response to frustration, directed against the clinicians and the setting perceived as an obstacle to the immediate gratification of his needs.

As an infant and toddler, Carl enjoyed lots of one-to-one time with his mother whilst his elder half brother attended school. Historically, Carl's mother has been Carl's main parent figure at home whilst Carl's father has needed to work long hours in the construction industry. This included Carl's father working away from the family home when Carl was two years old to support the family financially. He returned home on a 3-weekly basis over a period of 18 months.

Carl was at home during the first national lockdown and his aggression was evident. Carl's mother worked hard to minimise the experience of frustration by ensuring he had lots of individual attention.

Within clinical sessions, we have thought with Carl's mother about how Carl connects with another on a one-to-one (dyadic) basis. At times, Carl's aggression communicates feelings he is unable to display in another way or to verbalise. These are often in relation to his experience of, or fear of losing the connection with another when a third person or object intervenes. Very young children can experience this intrusion as rivalrous which can feel like an attack on the world that they are creating for themselves.

Children move from an initial dyadic relationship, often with their mothers, into a relationship often with both parent figures (triadic), and progress to develop a capacity to latterly engage in relations with extended family and peer group relations at school. Carl's struggle to move from dyadic to triadic relationships was apparent in our attempts to hold online sessions with Carl and his mother. We observed that Carl acutely felt the intrusion of the ‘screen’, as the intrusion of a ‘third’ into his enjoyable dyadic time with his mother. In one clinical session, Carl demanded that Carl’s mother used both her hands to play a ball game with him, while she attempted to hold the screen to enable our observations.

Utilising the knowledge we were gathering about Carl’s emotional development, Carl’s mother was open to actively facilitate further sessions incorporating the knowledge about Carl feeling pushed out in some way by the clinicians on the screen. Carl was more amenable to a session where Carl’s mother was able to play on the floor with him, whilst positioning the computer screen in the room. In this session, Carl showed curiosity in us as clinicians on the screen when it was more on his terms. With scaffolding support to help him to manage in a triadic relationship, there were no reported incidences of aggression.

Separation anxiety

We have also considered how Carl experiences the loss of connection with others, even temporarily. One aspect of this is how Carl manages his connection with his father when he returns home from work. Carl balances the pleasure of being re-united with his father, alongside more difficult feelings of being cross and sad about the loss of him whilst he is at work. At times this can be presented as a mixture of wishing to cuddle and hold onto his father, which can tip into a controlling, smothering way of relating to his father. Of course, very young children like Carl are unable to know how long a separation from a parent figure might be for; the much-needed predictability of life can be hard to maintain even in everyday routines.

At times, Carl’s mother has taken the force of Carl’s hurt feelings, either through his play or through displays of aggression towards her. Children often benefit from a parent acknowledging and verbalising the experience for example by stating, ‘how hard it is to not see Mummy/Daddy when they are not there’ and by the parent understanding that the child can feel both anger and joy when the ‘lost’ parent returns. Through this experience of having their less desirable feelings being contained and acknowledged by another, children can learn over time to contain some of these more difficult feelings themselves.

We have observed how Carl attempts to understand these emotional experiences for himself by introducing games involving hide and seek themes. Such re-enactments are crucial for young children to experience the concept of someone who leaves, then comes back. Carl’s mother has also been working with Carl between sessions to introduce a language around feelings and to help him to understand a little more about the reciprocity that exists in our emotional communication with another.

Emotional developmental delay

In gaining a better understanding of Carl's use of aggression at times, we have thought with Carl's mother about how she can help Carl to support his emotional development with a view to managing better in school. Carl's mother and professionals working with Carl have recognised the importance of him being supported to manage frustration. Carl responds better to predictable routines and changes to this can result in him feeling disrupted, communicated in his disrupted behaviour patterns.

When Carl's mother was required to return to her work following the ending of lockdown, alongside an increase in Carl's father's working hours, Carl's behaviour was reported to decline for a short period. He displayed his temper in response to the change in what had become a predictable and enjoyable experience at home with his parents and elder brother during the national lockdown. Carl was able to adjust to these changes relatively quickly. He benefits from an approach at home where there is not only routine, but also where he is not overwhelmed by too many activities. Carl's mother has worked hard to minimise the number of tasks being undertaken each day, alongside his enjoyment of long walks and bath-times.

During clinical sessions, we were pleased to hear Carl's mother report improvements in Carl's ability to tolerate frustration, for example, wait for his needs to be met by another. This has been coupled with Carl being able to make use of the speech and language support provided by you in helping Carl progress to verbalise his needs more clearly, reducing his frustration with others. Importantly, he is more able to tell another when they interpret his needs wrongly without needing to resort to aggression.

We have observed Carl's mother's thoughtful approach to considering Carl's transition into school and what he would find manageable in terms of his attendance and environment. During the clinical intervention, Carl was provided with an Educational Health Care Plan (EHCP) and a decision was reached that his educational needs would be best met by a specialist provision. We were in support of this decision, as it was evident that Carl would find a busier environment more difficult to manage and he may experience his peers as rivals, again creating feelings of aggression and attack in Carl without additional support to manage this.

Through the support of staff at school, we are pleased to hear that Carl has successfully transitioned school. He benefits from a small class (nine pupils) and more teaching resource (5 members of staff). He is able to access provision for his sensory needs through sensory circuits each day. Feedback received from his teachers was that he had settled well into school, and he gets along with his peers and greets and hugs them in the morning. Carl continues to display lots of energy and enjoys games involving chasing his classmates. He continues to show some difficulties managing rivalrous feelings as previously outlined and this manifests in some difficulties in sharing. This is managed well through school support and mechanisms to help Carl feel that his school experience is more predictable through ‘now and next’ visual timetables.

It is evident that this smaller, more attentive provision has helped Carl to thrive and their awareness of his difficulties in managing when he feels others intrude in his environment will help Carl to be supported further in this area. We were pleased to hear that Carl has recently received letters from two friends at his school and he is beginning to form positive connections with others. Given Carl’s initial difficulties in moving from a dyadic to triadic relationships, this is significant progress. Carl is also learning to count and is now able to draw a picture of a face. He has continued to attend school during the more recent national lockdowns due to his parent’s employment continuing. This regularity of routine no doubt contributes to Carl’s experience of stability and consistency.

Mimicking animal behaviours

At the time of your referral, Carl had been observed to mimic the behaviours of animals including dogs, lions and dinosaurs. We have thought with Carl’s mother how at these times, Carl appeared to identify with an aggressor, in the form of scary animals for Carl. Stepping into the role of a scary animal provided Carl with an experience of imaginatively taking up a more confident, omnipotent role, which is very often utilised by very young children to manage feelings of vulnerability, whether it be taking up the role of powerful animal characters or superheroes. Children gradually develop more mature ways of managing feelings of vulnerability. During the course of the clinical intervention, Carl’s mother observed that these behaviours ceased and within clinical sessions this behaviour has not been observed.

Recently, Carl has begun to mimic animals again, seemingly a regression in response to heightened anxiety. We have considered the change in this behaviour to one in which Carl likens himself to an animal, at present a dinosaur, but this is less about his wish to appear scary and frighten others away. He now mimics how a dinosaur walks with stomping feet and holding his arms like a T-Rex. The emphasis now is on imagining himself to be stronger and more solid.

Parental support

Throughout the intervention offered, Carl's mother's sensitive and thoughtful approach to working with us in order to understand Carl's difficulties, and to reflect on her responses to this, has been a significant reason why we feel Carl has progressed in his current development.

At the time of the clinical intervention, Carl's mother was also dealing with concerns raised about her elder son due to an anonymous referral to social care, which she believed was made by her ex-partner. We observed that Carl's mother engaged with Social Care and Early Help Services when required to assess the concerns. We were pleased to hear that both services did not feel they were required to provide an on-going role. Such experiences however can impact upon parental confidence and part of the parental support that we have provided has been to acknowledge Carl's mother's strengths, as well as the importance of accessing available specialist help to meet Carl's on-going needs when required.

Recommendations

A recent review of Carl's progress has noted improvements in aspects of Carl's behaviours that had been impacting upon daily life. A review 'Strength and Difficulty' questionnaire has highlighted a reduction in emotional symptoms, peer relationship difficulties and improvements in pro social behaviours. Building on the foundation of support provided by paediatric interventions has enabled us to further assess Carl's needs, and enabled Carl's mother to feel that the brief parent-child psychotherapy intervention has helped to improve her understanding and contributed to Carl's progress in all three areas of focus of the intervention.

Within clinical sessions, we have been pleased to see Carl's progress in development and how lively and engaged he is when communicating directly with another and feeling held by their attention. Through the support provided by your intervention, we have observed Carl's development from using mainly non-verbal communication to increasingly more verbal communication. Carl now shows a wish to connect with others and Carl's mother supports him to achieve this. His sociable personality would support an optimistic view of Carl's longer-term ability to relate to others. He is a charismatic young boy, who has a likeable and at times cheeky disposition.

We plan to have an in-person session with Carl’s mother and Carl’s father to begin to consolidate the progress that Carl has made to date, and we will write again to share further thoughts with you when our intervention has been completed.

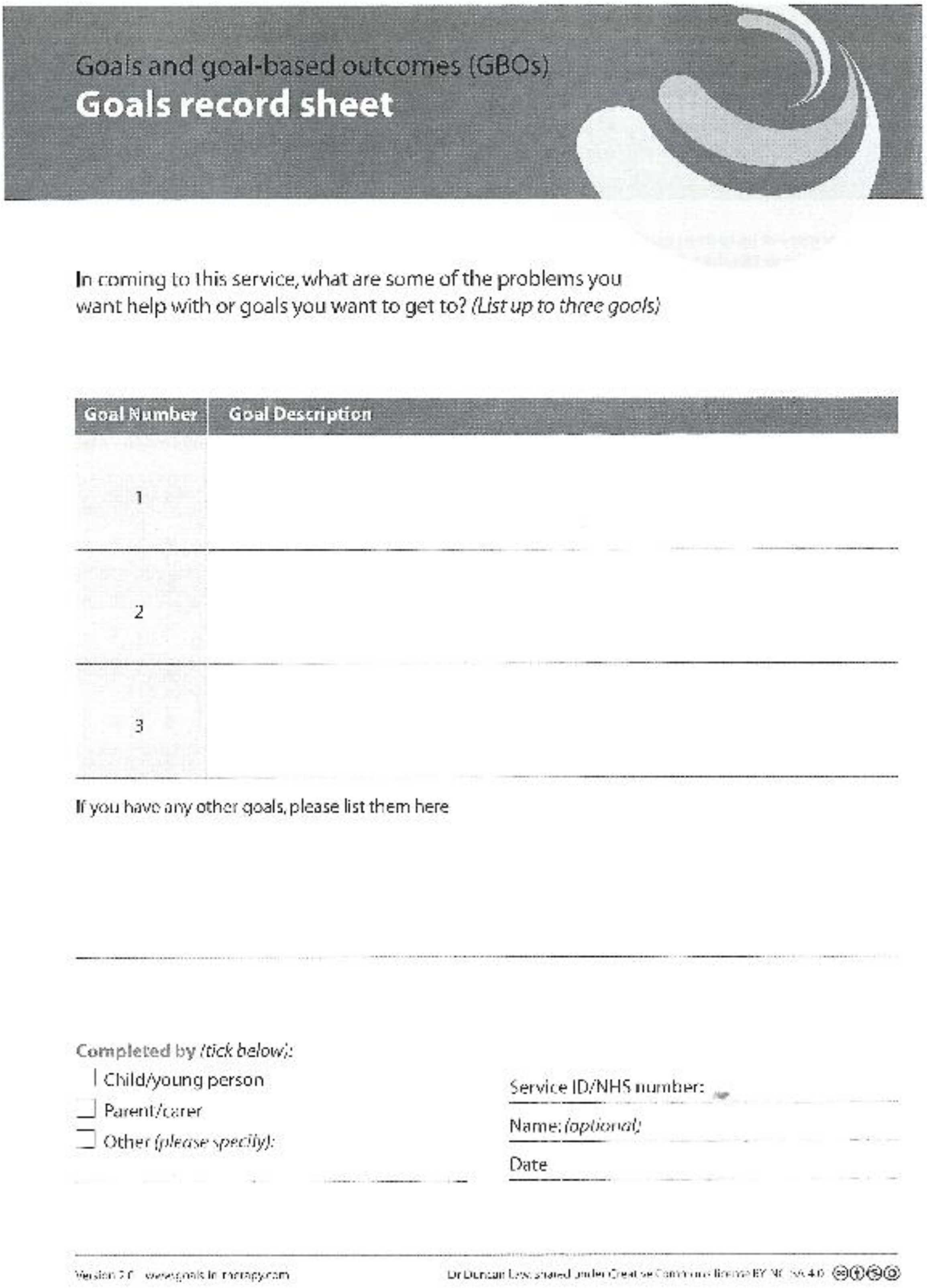
Yours sincerely,

Chief Investigator

8.9 Example of semi-structured interview data

Research question	Transcription of data	Initial noting	Feeling/experience
Q.13 Based on your current experience of the service; would you consider referring further children to the intervention? Why?	Yeah definitely because you're getting a bigger picture erm	positive towards intervention; feeling of being able to zoom out and see more than is possible for them	Positive about intervention; values a macro view of a child/family
	its helping to support the parents understanding the psychological element of what their child is presenting with and that's something we can't do because we're not trained in that field.	is able to acknowledge the deficit in knowledge/training; helping parent understand the child's psychological functioning is what they can't provide	De-skilled; lacking in knowledge/training; values trained professional's support
	erm...it helps us kind of learn as well and learn and develop our practices and gives us tips about what we should maybe be doing or should be looking at..	willing to take advice, consider another perspective, process of learning	values learning and working with others
	erm...I think it can avoid kind of diagnosis being made wrongly as well like in these types of cases erm if you can build that rapport and its not to say that just because we think a child hasn't got erm a diagnosis that they haven't got it..	avoids mis-diagnosis; do some children miss out on a diagnosis?; is willing to be proved wrong; something in the relationship/the rapport that can help with the assessment	fallible; wants to work closely with parents to understand the child's behaviour
	they could still have that diagnosis and it could be that presentation but it's looking at that bigger picture of why they are presenting in that way.	something about completeness; not focus on the small details? Broad overview: trying to understand the why before you diagnose/treat	Undecided at times; values considering the complete presentation

8.10 Goal Based Outcome questionnaire



Goals and goal-based outcomes (GBOs)

Goals record sheet

In coming to this service, what are some of the problems you want help with or goals you want to get to? *(List up to three goals)*

Goal Number	Goal Description
1	
2	
3	

If you have any other goals, please list them here

Completed by *(tick below)*:

☐ Child/young person

☐ Parent/carer

☐ Other *(please specify)*:

Service ID/NHS number:

Name: *(optional)*

Date

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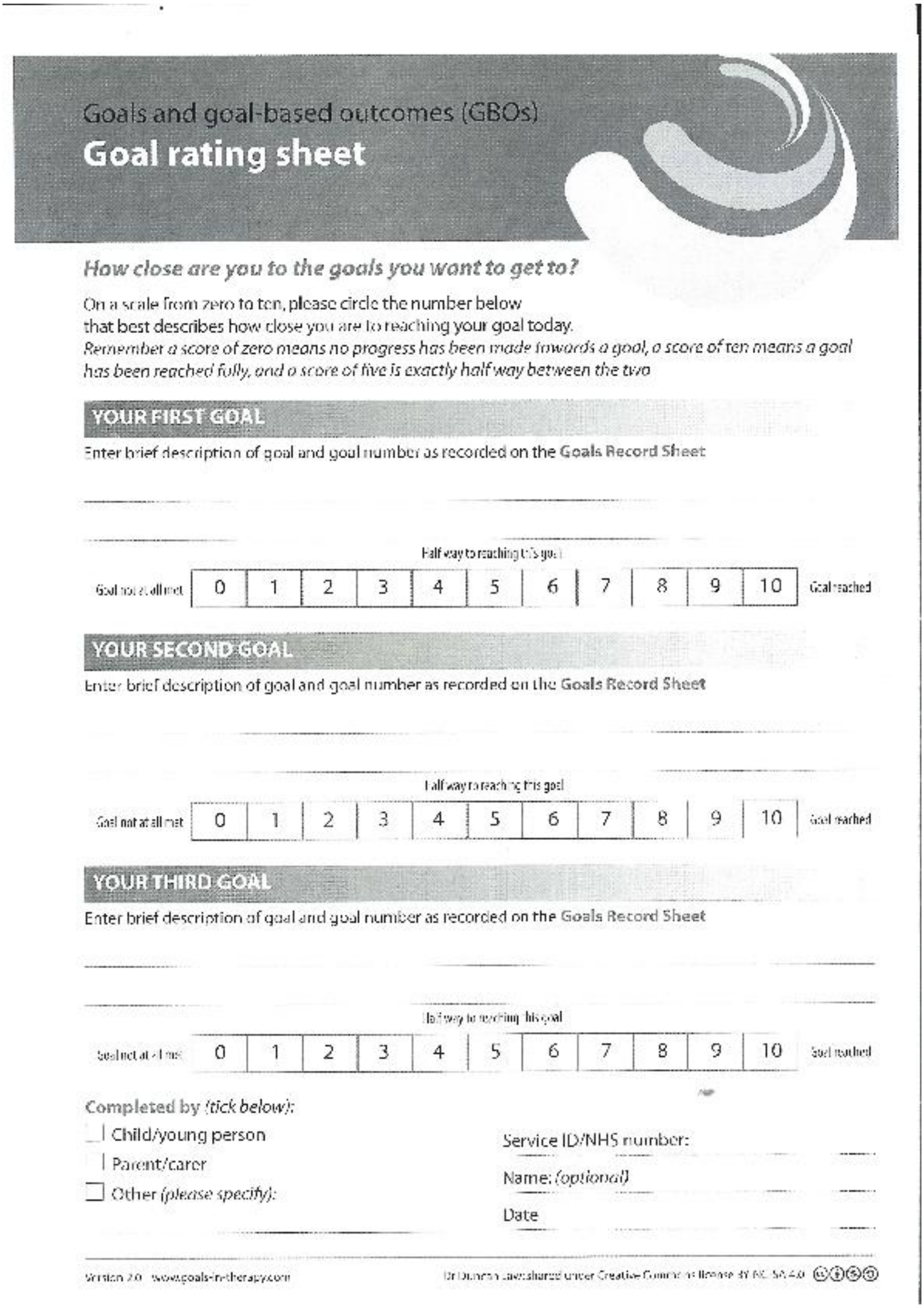

Goals and goal-based outcomes (GBOs)

Goal rating sheet

How close are you to the goals you want to get to?

On a scale from zero to ten, please circle the number below
that best describes how close you are to reaching your goal today.
Remember a score of zero means no progress has been made towards a goal, a score of ten means a goal has been reached fully, and a score of five is exactly half way between the two

YOUR FIRST GOAL

Enter brief description of goal and goal number as recorded on the **Goals Record Sheet**

Half way to reaching this goal

Goal not at all met	0	1	2	3	4	5	6	7	8	9	10	Goal reached

YOUR SECOND GOAL

Enter brief description of goal and goal number as recorded on the **Goals Record Sheet**

Half way to reaching this goal

Goal not at all met	0	1	2	3	4	5	6	7	8	9	10	Goal reached

YOUR THIRD GOAL

Enter brief description of goal and goal number as recorded on the **Goals Record Sheet**

Half way to reaching this goal

Goal not at all met	0	1	2	3	4	5	6	7	8	9	10	Goal reached

Completed by *(tick below)*:

☐ Child/young person
☐ Parent/carer
☐ Other *(please specify)*:

Service ID/NHS number:
Name: *(optional)*
Date

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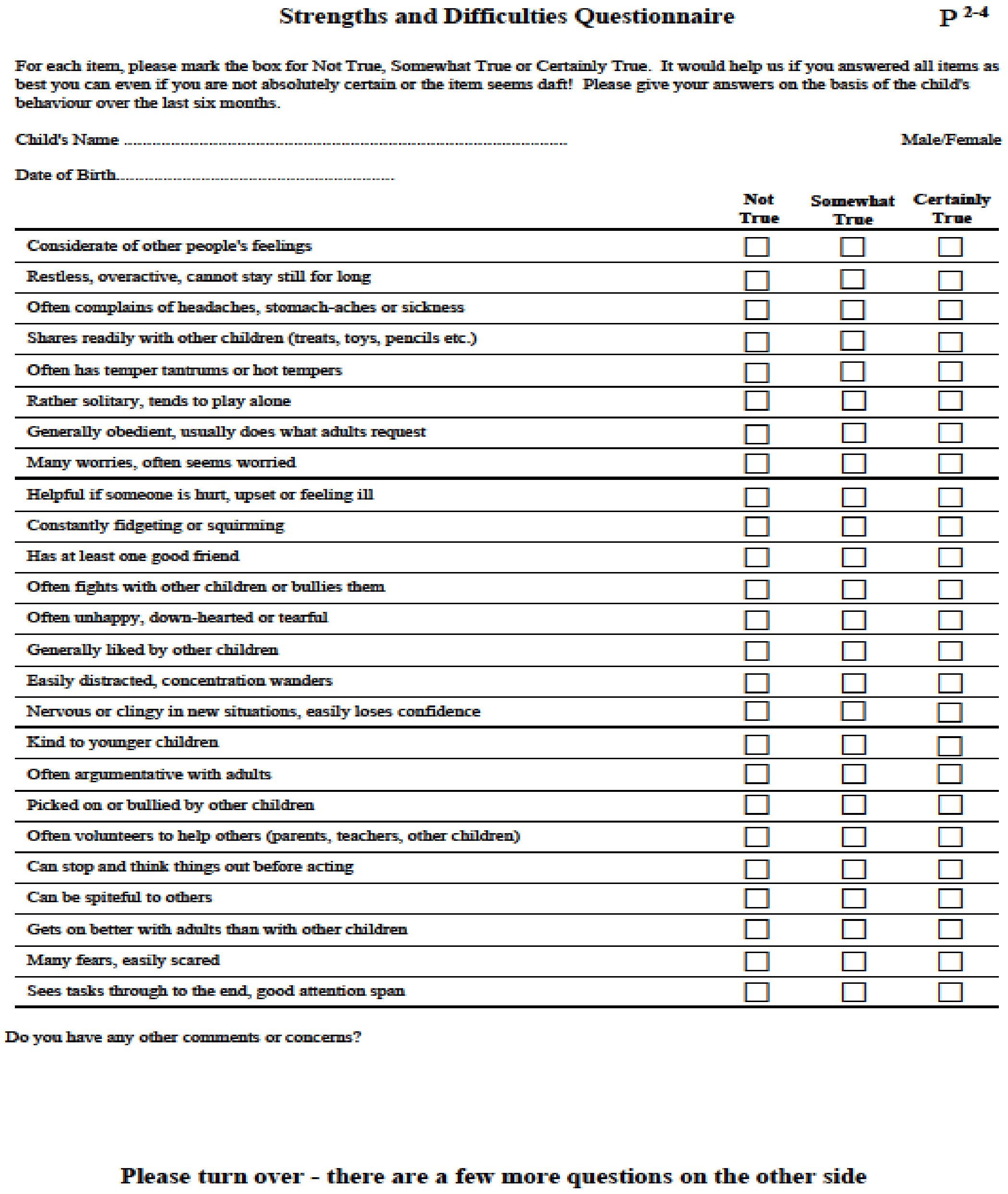
8.11 Strengths and Difficulties questionnaire



Strengths and Difficulties Questionnaire

P 2-4

For each item, please mark the box for Not True, Somewhat True or Certainly True. It would help us if you answered all items as best you can even if you are not absolutely certain or the item seems daft! Please give your answers on the basis of the child's behaviour over the last six months.

Child's Name .... Male/Female

Date of Birth..

	Not True	Somewhat True	Certainly True
Considerate of other people's feelings	☐	☐	☐
Restless, overactive, cannot stay still for long	☐	☐	☐
Often complains of headaches, stomach-aches or sickness	☐	☐	☐
Shares readily with other children (treats, toys, pencils etc.)	☐	☐	☐
Often has temper tantrums or hot tempers	☐	☐	☐
Rather solitary, tends to play alone	☐	☐	☐
Generally obedient, usually does what adults request	☐	☐	☐
Many worries, often seems worried	☐	☐	☐
Helpful if someone is hurt, upset or feeling ill	☐	☐	☐
Constantly fidgeting or squirming	☐	☐	☐
Has at least one good friend	☐	☐	☐
Often fights with other children or bullies them	☐	☐	☐
Often unhappy, down-hearted or tearful	☐	☐	☐
Generally liked by other children	☐	☐	☐
Easily distracted, concentration wanders	☐	☐	☐
Nervous or clingy in new situations, easily loses confidence	☐	☐	☐
Kind to younger children	☐	☐	☐
Often argumentative with adults	☐	☐	☐
Picked on or bullied by other children	☐	☐	☐
Often volunteers to help others (parents, teachers, other children)	☐	☐	☐
Can stop and think things out before acting	☐	☐	☐
Can be spiteful to others	☐	☐	☐
Gets on better with adults than with other children	☐	☐	☐
Many fears, easily scared	☐	☐	☐
Sees tasks through to the end, good attention span	☐	☐	☐

Do you have any other comments or concerns?

Please turn over - there are a few more questions on the other side

Overall, do you think that your child has difficulties in one or more of the following areas: emotions, concentration, behaviour or being able to get on with other people?

No	Yes- minor difficulties	Yes- definite difficulties	Yes- severe difficulties
☐	☐	☐	☐

If you have answered "Yes", please answer the following questions about these difficulties:

- How long have these difficulties been present?

Less than a month	1-5 months	6-12 months	Over a year
☐	☐	☐	☐

- Do the difficulties upset or distress your child?

Not at all	Only a little	Quite a lot	A great deal
☐	☐	☐	☐

- Do the difficulties interfere with your child's everyday life in the following areas?

	Not at all	Only a little	Quite a lot	A great deal
HOME LIFE	☐	☐	☐	☐
FRIENDSHIPS	☐	☐	☐	☐
CLASSROOM LEARNING	☐	☐	☐	☐
LEISURE ACTIVITIES	☐	☐	☐	☐

- Do the difficulties put a burden on you or the family as a whole?

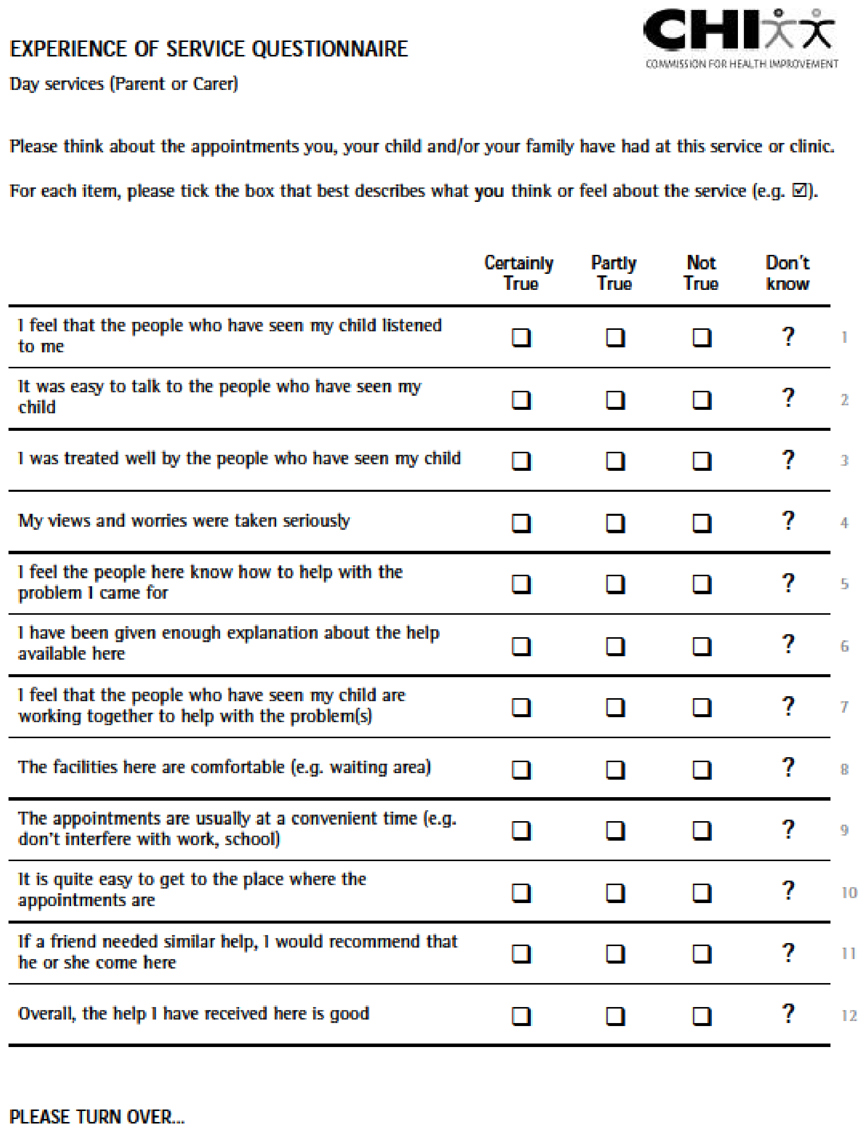
Not at all	Only a little	Quite a lot	A great deal
☐	☐	☐	☐

Signature .... Date ....

Mother/Father/Other (please specify:)

Thank you very much for your help

8.12 Experience of service questionnaire



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COMMISSION FOR HEALTH IMPROVEMENT

EXPERIENCE OF SERVICE QUESTIONNAIRE

Day services (Parent or Carer)

Please think about the appointments you, your child and/or your family have had at this service or clinic.

For each item, please tick the box that best describes what you think or feel about the service (e.g. ☑).

	Certainly True	Partly True	Not True	Don't know	
I feel that the people who have seen my child listened to me	☐	☐	☐	?	1
It was easy to talk to the people who have seen my child	☐	☐	☐	?	2
I was treated well by the people who have seen my child	☐	☐	☐	?	3
My views and worries were taken seriously	☐	☐	☐	?	4
I feel the people here know how to help with the problem I came for	☐	☐	☐	?	5
I have been given enough explanation about the help available here	☐	☐	☐	?	6
I feel that the people who have seen my child are working together to help with the problem(s)	☐	☐	☐	?	7
The facilities here are comfortable (e.g. waiting area)	☐	☐	☐	?	8
The appointments are usually at a convenient time (e.g. don't interfere with work, school)	☐	☐	☐	?	9
It is quite easy to get to the place where the appointments are	☐	☐	☐	?	10
If a friend needed similar help, I would recommend that he or she come here	☐	☐	☐	?	11
Overall, the help I have received here is good	☐	☐	☐	?	12

PLEASE TURN OVER...

What was really good about your care? 3

Was there anything you didn't like or anything that needs improving? 14

Is there anything else you want to tell us about the service you received? 15

Child's age:

Child's gender: Female ☐ Male ☐

Child's ethnicity: White ☐ Black/Black British ☐ Asian/Asian British ☐

Mixed ☐ Other ☐

Is your child registered disabled (e.g. hearing-impaired)? No ☐ Yes ☐

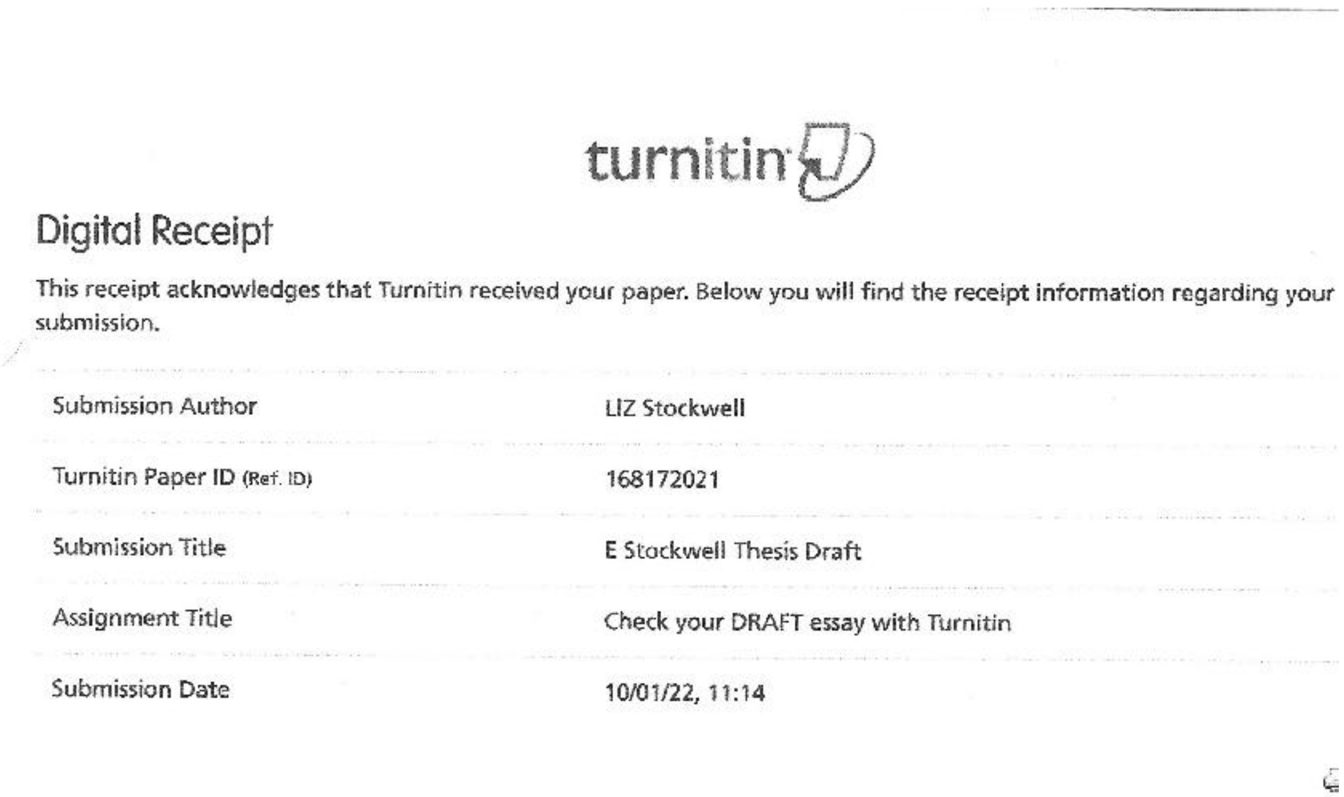
If you don't want to take part please tick this box ☐ and return the blank questionnaire in the envelope provided.

THANK YOU FOR YOUR HELP

Now place this form in the envelope provided and put it in the box marked CHI in the reception

For administration purposes
Ref:
Service: Date:
Time: DB No:

8.13 Turnitin receipt



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