The Contribution of Child Psychotherapy to Work with Parents and Infants in the Baby Clinic of a GP Practice

March 2022

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A thesis submitted in partial fulfilment of the requirements of The Tavistock NHS Trust and University of East London for the Professional Doctorate in Child Psychoanalytic Psychotherapy

Acknowledgements

This thesis is dedicated to Louise Emanuel and Dilys Daws. Their intelligence, tenacity, and commitment to work with under-fives will inform my work forever.

This thesis is also dedicated to the GPs, health visitors and families at the GP practice from whom I learnt so much.

I would like to thank my research supervisors Jenifer Wakelyn and Biddy Youell for their knowledge, expert guidance, and support.

I am eternally grateful to my family and friends for their love, encouragement and cheering me on.

Abstract

Perinatal mental illness affects up to 20% of mothers and their babies (NHS England 2022). GPs and health visitors are often the first port of call for parents and infants in distress. For over 40 years, the GP practice in this study has been home to a child and parent-infant psychotherapy service, supporting parents and infants with emotional and mental health needs and providing consultation to the GPs and health visitors who provide vital support to these families.

The aim of this research project was to explore the contribution that a child and parent-infant psychotherapy service in a GP practice makes to supporting parents and infants. This was a qualitative research study. The literature review examined literature on consultation and clinical work by psychotherapists in primary care and in parent-infant psychotherapy, policy and training for GPs and health visitors in the areas of perinatal and infant mental health.

The research was conducted using semi-structured interviews and analysing the psychotherapy session notes from sessions with parents and babies. Three interviews and three session notes were analysed using Interpretative Phenomenological Analysis (IPA). The main findings of this study are that parents and infants in distress can be supported by primary care clinicians when they are able to: provide continuity, encourage agency, develop, and use their observation skills, pay attention to unconscious and emotional communication, be interested and receptive and take a holistic view.

This thesis offered recommendations for future research and future practice in child psychotherapy in primary care with GPs and health visitors.

Declaration

I hereby declare that the contents of this thesis are entirely my own work; ideas and written work from other sources of information have been identified and referenced throughout. Issues pertaining to confidentiality and research ethics have been comprehensively assessed and considered. This project has received ethics clearance from the NHS Health Research Authority.

Chapter 1: Introduction

‘In a baby clinic, babies’ bodies are examined… looked at, appreciated, and measured by parents and professionals’ (Daws, 2005, p.22). In the clinic, attention is paid to the baby’s development and the bond between parent and baby. As the naked, vulnerable baby is lifted from warm arms into the cold basin of the weighing scales, the mother’s instincts to protect her baby kick in. The child and parent-infant psychotherapy service described in this research project is based in a community health centre where a GP practice, health visiting, and baby clinic services are provided. This research study investigates the contribution of child psychotherapy to supporting parents and infants who access the baby clinic and the clinicians working there ‘.

Every Thursday morning the GP practice opens the doors to its baby clinic for parents and infants. Babies are weighed, measured, vaccinated, and seen by GPs and health visitors. Their parents’ concerns are thought about and talked about. In a busy, bustling clinic alive with the sounds of babies and parents, physical needs such as the baby’s weight or vaccinations are of primary concern. In carrying out this study, I hoped to find out more about how the early emotional experiences of parents and babies are communicated and supported.

Health visitors and GPs are the first port of call for parents and infants in distress. So much of the baby’s first experiences and first experiences of care and containment are physical. Babies are swaddled, held when they cry, soothed, and fed at the breast. Meanwhiles, their parents try to understand what may be going on inside them that is causing upset. Daniel Stern (1985) writes about how

babies need another person to experience their own bodies. They need the physical mediation of another to satisfy their hunger, clean and burp them and help them get off to sleep. When parents come to a baby clinic or their GP with worries about their baby's sleep, feeding or physical health, they know that someone will be interested in the physical. They may also be hoping consciously or unconsciously that someone will pay attention to the emotional challenges they face raising their baby. There may be an unconscious hope in the parent that by speaking to a professional about their worries about their baby, the professional will take care of them too.

Michael and Enid Balint (1979) were pioneers in bringing a psychoanalytic understanding of the patient-doctor relationship and the relationship between patient, illness, and doctor to primary care. They brought their understanding of the transference relationship that emerges between patient and psychoanalyst to the subject of doctor-patient relationships. They were interested in understanding and supporting GPs to understand the emotional meanings that physical illness has in our minds and the emotional dynamics that can emerge between patient and doctor.

Psychotherapists working in healthcare settings take on the task of providing therapeutic support to adults, children, parents, infants, and families in settings where concerns about the body and physical health are central. Their task is to work therapeutically with patients and to understand the emotional underlay to physical health difficulties and experiences. For Launer (2005), the task of the psychotherapist in the GP practice has always been threefold: seeing and supporting patients therapeutically, providing specialist consultation and advice

to primary care staff, and playing a role in the education of primary care clinicians about the mental health and emotional needs of patients.

Consultation with the psychotherapist in the GP practice provides opportunities for clinicians to talk about their anxieties about patients. Through the process of listening carefully to the clinician's concerns about the patient, the psychotherapist can help the clinician understand what the patient might be communicating unconsciously to the clinician. However, for a psychotherapist to be accepted into a GP practice, there must be an openness in the staff team to the idea of an unconscious and the existence of unconscious communication in patient-doctor relationships.

In the GP practice where this study took place, there was a long history of thinking and talking about unconscious communication. Dilys Daws, the consultant child psychotherapist established the parent-infant psychotherapy practice in this study in the mid-1970s. The service ran consistently over 40 years, half a day per week, including in a reduced, remote capacity during the Covid pandemic lockdown. Whilst other GP practices with child psychotherapy services and input certainly exist, this practice is probably unique in the duration of the service and input and familiarity with child psychotherapy. There were other strong links between the practice and psychoanalytic approaches. The GPs at the practice were members of Balint groups and the practice had strong links with the Tavistock Clinic. During the 1970s the Tavistock Community Unit, a team of clinicians from the adult and child and family departments at the Tavistock working in GP practices and other community outreach settings, were involved in the practice.

I undertook a placement working in the parent-infant and child psychotherapy service at the GP practice during the last two years of my training as a child and adolescent psychotherapist. The placement lasted two years, including six months after I qualified, during which time I carried out data collection for this study. During the first months of my placement, I spent time in the baby clinic using the psychoanalytic method of observation to learn more about how parents and infants interacted in the baby clinic. I was struck by what these observations revealed about the relationships between parents and babies and between families and professionals. I noticed how health visitors and GPs would find opportunities to speak to me about families they were concerned about during my visits to the clinic. Their accounts were rich with observations and descriptions of what they experienced and felt when working with distressed parents and infants. I was interested in how they used their observations and the countertransference feelings they experienced in their work with parents and infants. I wondered whether being attuned to the emotional state of parents and infants and carefully observing interactions between parents and babies was common practice amongst health visitors and GPs.

On a weekly basis, I dealt with all aspects of the child psychotherapy service. This included discussing referrals with the lead psychotherapist and referrers, seeing families for psychotherapy, and liaising with the professional network around them. I noted how the emotional experience of each of these encounters helped to build up a picture of the parents and baby who were coming to the service seeking help. I saw families together with the consultant child psychotherapist and on my own for parent-infant psychotherapy. We worked with

the families to gain a better understanding of what had led them to seek help, what they were struggling with and how they communicated their struggle and distress. Meeting the parent and baby together in psychotherapy sessions, and observing the relationship and emotional communication between them, made it possible to listen to their concerns and help them feel understood. I learnt how by paying close attention to unconscious communication, using observation, listening attentively, and providing containing, regular sessions, parents could start to feel more confident about their capacities to understand and bond with their babies and change could happen relatively quickly. Sometimes, hearing and witnessing the challenges some families faced was worrying and painful.

Seeing examples of non-verbal unconscious communication and its place early in the lives of babies and new parents was eye-opening. For instance, seeing a baby aged eight months move to stroke and comfort his mother when the mother became upset and tearful in a psychotherapy session. Or, noticing a mother who felt she could not manage when her baby cried, notice her baby make gaps between each cry, as though giving her mother gaps or moments when she could talk to her, to soothe her, was fascinating. It was rewarding was to see these relationships change and mothers report feeling better, enjoying their babies and their lives more as the sessions progressed. I wanted to find a way to explore what in parent-infant psychotherapy and the child psychotherapist's approach that helps parents and infants and the relationships between them return to a healthier developmental track.

In this research study, my aim was twofold:

First, to explore the kind of contribution that a child psychotherapy led parent-infant psychotherapy service has made in supporting parents and infants in distress. This research study was designed with the aim of collecting and analysing data that might reveal what it is that child psychotherapy might contribute to understanding, supporting, and treating early distress in new parent and infants in a GP practice. I set out to carry out therapeutic work with parents and infants and to record the sessions in detailed process notes. I planned to use Interpretative Phenomenological Analysis (IPA), a qualitative research tool that aims to explore how people make sense of their experience, to analyse the process notes.

Second, I aimed to find out how having a child psychotherapist providing consultation and a parent-infant psychotherapy service might support the clinical work of GPs and health visitors with parents and infants. I planned to carry out semi-structured interviews with the GPs and health visitors working in the baby clinic of the GP practice. In so doing, I aimed to learn about the experiences of these clinicians working with parents and infants. I hoped these interviews and analysing the interview material using a qualitative research methodology would provide insight into the psychological support that interactions between parents, infants and medical staff can provide. Once transcribed, I would also analyse the interview material using IPA.

I initially hoped to carry out observations in the baby clinic as part of the research study. However, I realised early on in the design of the study that obtaining ethical approval for this aspect of the project would be impossible.

I was driven to undertake this research study and to see it through by various motivating factors. Some of these were personal and feel important to mention. In my training placement in CAMHS (child and adolescent mental health services), I was invited to join a small team dedicated to working with under-fives and their parents. This team was led by my service supervisor, Louise Emanuel, who was both inspiring and encouraging of trainees' work with children and families. It is thanks to her enthusiasm, warmth, intelligence, and commitment to supporting parents and children, that we were given rich opportunities to develop our skills and projects in the clinic and community. We supported one another by offering each other different perspectives, sharing our work and reflections. We also found ways to look after each other when the work was particularly tough.

I found echoes of this supportive ethos and culture when I was offered the opportunity to work in the parent-infant psychotherapy service at the GP practice. In the service, parents and their children are seen together, and, where possible, two therapists see the family together. The work can be emotionally challenging, but it can also feel very creative. Positive changes in how parents and their infants feel about themselves and their relationships can be seen in a short period of time. It is common for there to be a strong feeling of collaboration between practitioners and parents. It can feel like being part of a strong parental couple or group of parents trying to work out how to address difficult challenges faced by their children. I believe this way of working can counter the isolation and loneliness that some mothers can feel with their babies.

There are also aspects of the clinical work that I related to personally. A common theme amongst the international families referred to the service was the struggles

they faced feeling alone, adapting to a new country, health service and community far away from their own families and communities of origin. As a child, my family and I moved country. This offered opportunities and possibilities for my family, but it also involved leaving friends and family behind, adapting to a new country, and facing life changes in a new environment

Working at the GP practice was a formative experience during which I learnt about the value of early intervention to support parents, young children, and the relationships in families. This experience continues to inform my clinical work and this research study.

1.1 Background and rationale to this study

Perinatal mental illness affects up to 20% of mothers and their babies (NHS England 2022) in the UK. A recent report by the Institute of Health Visiting (Homonchuk and Barlow, 2022) estimates that perinatal illnesses have an £8.1 billion cost for each one-year cohort of births in the UK. Seventy-two percent of these costs relate to adverse impacts on the child.

Early intervention services, including those provided by health visitors, mental health practitioners and GPs in primary care, play a vital role in supporting parents and families where there are perinatal mental health difficulties.

What can a child psychotherapy service in a GP practice contribute to meeting the mental health and emotional needs of infants and their parents? What contribution might a child psychotherapy service make to the learning and skills of health visitors and GPs supporting the emotional needs of parents and young children?

Conversations with GPs and health visitors about supporting parents and infants where there were high levels of emotional distress and mental health needs, greatly informed my understanding of the extensive capacities, skills, and sensitivity that primary care clinicians bring to their work with parents and infants. These conversations informed the thinking behind my study design. The study was also informed by conversations with the lead child psychotherapist, our clinical work together with families, joint work with GPs and health visitors, and observations I undertook in the baby clinic.

1.2 Study setting

The GP practice

The GP practice where this study took place is located in an inner-city area. It serves a population of around 20,000 patients. Patients from all five quintiles of the socioeconomic measures of income are represented in the patient population of the practice. Two-thirds of the population falls into categories one to three (where category one represents the highest earners, earning £69,390 and above), and a third of the population falls into categories four to five (category five has an annual household income of £13,390) (Healthwatch, 2019).

Health visitors, GPs, and the baby clinic

Health visitors and GPs get to know families and their difficulties by seeing them in the baby clinic or through home visits by the health visitor and general practice appointments. Each health visitor holds a caseload of families who attend the baby clinic. Parents bring their babies to the weekly clinic to be weighed and to

seek guidance on sleep, feeding, and other aspects of parent and infant physical and mental health.

The health visitor also gets to know the families on his or her caseload through at least two homes visits following the baby's birth: the 'New Birth Visit' and the 'Six to Eight Week Follow Up Visit'. All babies are required to be seen by the health visitor at home between 10 and 14 days following birth. They must be seen for a six-week review (this may take place at the baby clinic) by both the health visitor and GP (NHS Services and Support for New Parents, online 2022).

For over forty years, GPs and health visitors at the practice have referred young children and their parents to the parent-infant and child psychotherapy service. The baby clinic and parent-infant psychotherapy service are closely linked. The service was designed to offer therapy and consultation alongside the baby clinic. Therapists see patients in a consulting room nearby. In the service, the child psychotherapist starts and ends the day visiting the baby clinic. During this time, the health visitors or GPs may seek advice and consultation about a family they are concerned about. At the end of the weekly baby clinic, the health visitors hold a meeting to debrief, and the child psychotherapist joins this meeting.

The parent-infant psychotherapy service

Referral and Treatment

The vulnerability of the baby and parent to perinatal mental health difficulties often necessitates that a referral is made promptly. Whilst the need for quick response with under-fives is paramount, it can take time for a parent to share their worries and for a relationship of trust to be built between parent and primary

care clinician. GPs and health visitors need to act sensitively to gauge when it is the right time to suggest a referral to the parent-infant psychotherapy service.

Sometimes the clinician has a well-established relationship with the family or parent, sometimes there is an urgency to refer the family to the parent-infant psychotherapy service, and sometimes, the GP or health visitor recognise that a relationship needs to be built before the parent or family are ready to be referred on to the parent-infant psychotherapy service. Usually, the health visitor or GP has met with the family or parent on a few occasions before referring the family.

The parent-infant psychotherapy service receives referrals of parents and their young children (mainly, but not exclusively, babies) registered with the GP practice. Referrals are made through a referral form. Once received, the lead child psychotherapist and trainee psychotherapist consider the referral and the suitability for parent-infant psychotherapy. There are four possible outcomes from this intake process: the therapists may take the referral on, seek further information from the referrer and then take the case on or have a consultation with the referrer, to help the GP or health visitor find ways to continue supporting the family. They may also recommend that the family are referred on to more appropriate services, such as adult mental health or child and adolescent mental health services (CAMHS).

Once the parent-infant psychotherapy service has accepted the referral, the child psychotherapist and trainee plan to meet the family and discuss how to keep the referring GP or health visitor informed.

The first contact with the referred family comes through an initial phone call during which the child psychotherapist offers a first appointment. Although brief, this phone call is important. Parents are often anxious and worried about their baby. There is a risk of the parent's mood deteriorating so there is an urgency for the family to be seen and continue to be supported by the health visiting and GP team. It is for this reason that an appointment is offered the following week after the call.

The first phone call also offers the opportunity for the therapist to introduce him or herself and the link between the referrer and the therapy service. This can help reassure the parent that there is a link between the child psychotherapist and the baby clinic and GP or health visitor they are familiar with and have an existing relationship with. During this initial phone call, the parent is asked to consider who will come to the first appointment, whether both parents will attend, or he or she will attend on his or her own. The parent is encouraged to bring the baby to the appointment. The therapist explains that she will be in touch by phone the day before the appointment to confirm the appointment. This approach is aimed at ensuring the family know that they are being kept in mind and supported to come to the clinic.

The first appointment provides an introduction to the child, parents, and the presenting difficulty. During the first appointment, the therapist explains the frequency of sessions and how to make contact to cancel appointments. The therapist and parent start to think about what the parent and or family would like help with and goals for the treatment are agreed. Families are invited to start to think about what has brought them to seek help. The therapist takes a history of

the problem and an initial developmental history of the parent, family, and child. During this appointment, the therapists carefully assess risk.

Appointments take place initially weekly in the same consulting room at the GP practice and move to fortnightly in time. There is no set time period for weekly appointments to be moved to fortnightly appointments, but this usually happens after a couple of months of treatment and is dependent upon what the therapist assess to be the family's need.

Consultation

Being present and available to staff is important. Primary care clinicians have limited time and are often working under a lot of pressure. The child psychotherapy team makes sure they are available for health visitors and GP to meet to discuss a family during the baby clinic, the GP practice coffee break or may meet the GP or health visitor between their appointments. The consultation involves the child psychotherapist listening to and finding out about the family's concerns and the GP or health visitor's concerns about the family. The consultation process offers the opportunity to think about the family, the GP or health visitor's countertransference responses to the family (and what this might tell us about the emotional challenges the family is facing), and their difficulties and concerns. It can also form the basis for a referral to the parent-infant psychotherapy service.

Thinking about a referral can involve a lot of consideration on the part of the GP or health visitor, with the child psychotherapist's guidance, to decide whether parent-infant psychotherapy is the appropriate intervention or treatment, or

whether the health visitor or GP could support the concerns of the family sufficiently themselves.

Another way in which the service offers support is through joint appointments with the health visitor or GP where the child psychotherapist joins the health visitor or GP, in a meeting with the family.

1.3 Structure of the thesis

The structure of the thesis is as follows.

The following chapter covers my **literature review** (chapter two). In the next chapter, the **methodology** (chapter three) I will describe the study design and the methodology I followed, ethical questions I faced and reflections on the experience of conducting the research.

In the **findings** chapter (chapter four) I detail the main findings of this research study. In chapter five I present my **discussion.** In chapter six I present my **conclusions** .

Chapter 2: Literature review

2.1 Literature review strategy

The papers reviewed in this chapter originated from two phases in the research project. First, a general reading of qualitative research methodology and literature on psychotherapy with parents and their young children in community settings during the study design phase. I focused on literature on the Tavistock model of psychoanalytic psychotherapy with under-fives, journal papers published by child psychotherapists, and theoretical reading about psychoanalytic understandings of early states of mind. I also turned to policy papers on perinatal mental health and NHS guidelines on how to support the mental health needs of infants and their parents. I also took an overview of under-fives interventions and programmes used to support parents and young children in community, perinatal, and child and adolescent mental health services.

The second phase of the literature review took place once I had analysed the data and gathered my findings and involved a more in-depth appraisal and reading of the literature.

The first stage in my literature review and searches began by looking at papers by child psychotherapists working in primary care. I also read literature on psychoanalytic psychotherapy with children under five and their parents, relevant research, and NHS guidelines.

My first step involved looking at the literature in depth and looking at similar papers in the publications in which their papers appeared. I also used the lists of

references from these papers to find original cited sources and look for further relevant literature. It was during this phase that I discovered a wider range of literature covering the work of psychotherapists working in primary care and healthcare settings.

A second step in widening my search was to search the Tavistock and Portman library catalogue online resources. The timing of my literature research coincided with the arrival of the Covid-19 Pandemic, which meant that all my research was online, and this limited my access to paper books and journals.

Using the library catalogue brought further resources. Some of the richest range of results came from searching online journals, through EBSCO. I used EBSCO to search journals including the Journal of Child Psychotherapy, the Journal of Infant Mental Health, the British Journal of Psychotherapy, and the PEP archive. Using EBSCO gave me wider access to publications and journals carrying articles about health visiting, community practice, primary care, and therapeutic work in community settings. I also used references in papers and contacted specialists in the field for recommendations of literature. This was particularly the case when trying to develop my knowledge of the work of health visitors and to widen my search to include publications on the mental health role of health visitors and GPs. I also contacted the Institute of Health Visiting (IHV) to find out about publications on the mental health role and work of health visitors. I encountered restrictions trying to access journals such as the Institute of Health Visiting and primary care journals, so, where possible, I requested access from the institutions directly. I also referred to reading lists from conferences, training,

and workshops I attended and the reading lists from papers published and presented at these events.

In widening my search, I referred to online resources and the International Psychoanalytic Association's podcast interviews with psychoanalysts and psychotherapists applying psychoanalytic technique to various settings, including in consultation work and work with organisations. I consulted the website archives of organisations, including the Parent-Infant Foundation, 1001 Critical Days Manifesto, and the Association of Infant Mental Health UK.

Keyword and journal search

The searches I undertook in archives and journals involved searching using key words in order to deepen and widen the literature search. These are some examples of the key words combined and phrases I used to search:

'Child psychotherapy in healthcare settings'

'Psychotherapy in GP practice'

'Child psychotherapy' and 'consultation'

'Child psychotherapy' and 'GP'

'Consultation' and 'primary care'

'Health visitors' and 'perinatal mental health'

'Primary care' and 'infant mental health'

'GP' and 'perinatal mental health'

Sometimes, the above searches resulted in no or very few results in journals. This may be because whilst the papers may be about topics such as parent work with under-fives, consultation, or parent-infant psychotherapy, the titles of these

papers do not always include these keywords. I discovered that despite there being a history of child psychotherapists working in healthcare settings, there were few clinical papers discussing this.

To widen my search, I used Google Scholar. The widest set of results was gathered from references from key papers. These were papers that were most relevant to my research project. I looked these references up using Google Scholar and Research Gate which generated more relevant articles and results. I also referred to reading lists from the Infant Mental Health and Child Psychotherapy training courses at the Tavistock. This included reading lists developed to support learning in the Infant Mental Health and Parent Work workshops.

Phase two

This stage of the literature research involved in-depth reading, taking notes, and writing summaries of the key papers. Throughout this process, I kept a working document listing themes and authors and how the themes explored in papers linked to other papers.

Once I had detailed notes, I began to map out how the different papers and their themes linked to one another using diagrams and lists. I began an initial phase of drafting the literature review based on these lists. Eventually, I decided to write the literature review chronologically rather than as themes as this made for much clearer reading. Setting the literature out chronologically also followed the historical development of the application of psychoanalytic technique to working with children and parents and working in primary care.

I decided to divide my literature review into three sections that reflect the three key roles of the child psychotherapist in primary care: consultation, clinical work, and training. In the final section on training, I broadened the scope of my literature to include policies and commentaries on these policies and to provide an overview of training and support for health visitors and GPs.

During the data analysis phase and the writing up phase, I took my research findings to be discussed with a specialist under-fives clinical supervision group I had been a member of for four years. I presented my findings and sought their advice and guidance on relevant literature.

Inclusion and exclusion criteria

Inclusion

My literature review includes publications (including online resources) from 1941 to 2022. The literature review follows the history of the adaptation and application of psychoanalytic approaches to primary care up to 2020. I include policy documents, online material and papers covering the same period up until 2022.

The literature referred to covers psychoanalytic approaches to work with parents and young children, the application and clinical work of child psychotherapists in primary care ,and how these ideas and experiences are applied to consultation and supervision and can be applied to training.

Exclusion

During the study design phase, I familiarized myself with the literature on a range of under-fives interventions, including non-psychoanalytic under-fives

treatments. I looked at programmes and approaches aimed at providing parents and early-year practitioners with resources to manage emotional regulation, socialization, and behavioural difficulties in under-fives. One such approach is the Incredible Years (2007) programme devised by psychologist Dr Carolyn Webster-Stratton. Based on 30 years of research and development, the Incredible Years (2022) focuses on strengthening parental competency in order to promote children's academic, social and emotional skills and reduce conduct difficulties. Having worked in CAMHS under-fives services both during and since my placement in the service (completed in January 2018), I was familiar with these interventions and their application with families.

I also looked at literature on interventions used in specialist perinatal mental health services for parents with common and more complex mental health difficulties. These included interventions for depression and anxiety, such as Cognitive Behavioural Therapy (CBT); specialist interventions for birth trauma, such as Eye Movement Desensitisation Reprocessing (EMDR); and specialist interventions for parents with more complex mental health needs, such as obsessive-compulsive disorder (OCD) and personality disorders.

In my work with parents and infants, a working knowledge of these interventions has been vital in supporting families, working with other professionals, and making recommendations for support. However, I decided to exclude literature on these interventions for the following reasons. First, this study is not a comparative study, comparing what different psychological therapies contribute to supporting parents and infants in distress. This study is of a baby clinic where there are child psychotherapists trained in and applying psychoanalytic

approaches to parent-infant psychotherapy and where there are GPs and health visitors with training in mental health. These health visitors and GPs have learned through consultation by psychotherapists applying psychoanalytic understandings of perinatal and infant mental health to consultation. Second, this is a clinic where a psychoanalytic approach to working with parents and under-fives has a long history. It is a small service, run half a day a week by an honorary consultant child psychotherapist and trainees. Whilst well-established, it has not developed to recruit and include multi-disciplinary practitioners in its team. So, it did not feel appropriate to include literature in my search that described approaches not used in the service.

However, when it came to looking at the literature on the mental health training of health visitors, it helped to provide a deeper understanding of the role health visitors can play in supporting parental and infant mental health. Psychological therapies, even those delivered in perinatal mental health services and some psychology services for parents of under-fives, such as CBT for anxiety and low mood and interventions for OCD and personality disorders and trauma interventions, are designed for the parent to follow a particular set of steps, stages, and interventions. Parents are seen alone without their baby or partner for these interventions, usually for a time limited period and set number of sessions. These interventions have the specific focus of helping the parent. They offer interventions that are quite different in theoretical and practical approach to parent-infant psychotherapy.

Parent-infant psychotherapy delivered in Child and Adolescent Mental Health Services (CAMHS) or in outreach from CAMHS, in the NHS in the UK, is usually

delivered by child and adolescent psychoanalytic psychotherapists. Their training in infant observation, psychoanalytic theory, and child development are brought to this work. Like child psychotherapy, parent-infant psychotherapy is interested in the unconscious and is patient-led. In parent-infant psychotherapy, the therapist invites the parent and young child to take part, communicate, and bring their concerns to therapy (Salomonsson, 2015). Parent-infant psychotherapy is based on a free association technique where attention is paid to carefully observe interactions, the transference and countertransference. Stern (1995) writes that 'the patient' in the parent-infant psychotherapy session is the relationship between a baby and his or her parents. A relationship 'influenced by a rich and full past history on the parents' part and a quickly accumulating but still minimal one on the infant's part.' (Stern, 1995, p.3)

Parent-infant psychotherapy seeks to find 'ports of entry' into understanding and supporting parent-infant relationships (Stern,1995). 'Ports of entry' is a concept based on the idea that in each parent-infant relationship and difficulty, the concerns brought to the therapist are expressed by the family in different ways. For instance, the difficulty might be expressed as a difficulty with the child (e.g., sleep difficulties), a difficulty with the parent (e.g., a parent feeling depressed) or difficulties in the relationship between parent and infant (e.g., expressed as a bonding issue). Stern argues that each of these ports of entry represents a 'port of entry' or route to supporting the family.

My literature searches into the work of child psychotherapists in healthcare settings brought forward literature covering therapeutic work in both primary care and secondary care (hospital) settings.

2.2 Literature review

Consultation

In 1948, Michael and Enid Balint, both psychoanalysts, brought psychoanalytic understandings of the emotional relationship between doctor and patient to primary care. Informed by psychoanalytic understandings of the transference relationship between doctor and patient and the emotional relationship between the patient and their illness, the Balints developed their body of work and support for doctors through research groups at the Tavistock Clinic. These research groups encouraged doctors to listen to and develop their understanding of the emotional underlay to their patients' difficulties and to be curious and enquiring about the patient-doctor relationship.

In 1948, Michael and Enid Balint developed the Balint group. Consisting of around ten doctors and a psychoanalyst leading the group, each week a 'problem patient' would be brought by a doctor to be discussed. The doctor would bring a dilemma they faced with this patient. One doctor presented a dilemma with a patient and the rest of the group would listen. One of the initial aims was to help doctors to become good listeners. Over time, the focus switched to pay more attention to the relationship between the patient and the doctor (Salinsky, 2009).

Enid Balint (1979) ran research groups with parents and infants at the Tavistock when Michael Balint first started his work there. Later writers, including the psychiatrist and psychoanalyst Paulsen (2019), have suggested that these experiences of parent and infant groups may have shaped the later Balint groups.

In 1957, based on three years of research seminars at the Tavistock Clinic, Michael Balint wrote ‘The Doctor, his Patient and the Illness’. These weekly research seminars had brought together doctors, psychoanalysts, and psychiatrists to study the ‘psychological implications in general practice’. In other words, the psychological aspect of medical care with patients and the patient-doctor relationship.

Balint (1957) writes that one of the most important discoveries in these groups was what he would refer to as the ‘Apostolic Function’ of the doctor:

> *The discussions revealed – certainly not for the first time in medicine- that by far the most frequently used drug in general practice was the doctor himself, i.e., that it was not only the bottle of medicine…that mattered, but the way the doctor gave them to his patient – in fact, the whole atmosphere in which the drug was given and taken. (1957, p.279)*

Balint turned to the knowledge and experience he gained as a psychoanalyst to consider the dynamics that can emerge in the doctor-patient relationship. He observed that in both the psychoanalyst-patient relationship and the doctor-patient relationship ‘one person in the relationship is in the position of superior, in so far as he has more knowledge, better and deeper understanding’. For Balint (1957), this ‘lop-sided’ dyadic relationship exists between analyst and patient and between doctor and patient. Highly charged emotions are transferred to the analyst by the patient. The analyst must tolerate and make sense of these emotions. Balint found that the same unconscious communication took place between patient and doctor. The doctor also receives and must tolerate powerful

emotions from the patient when the patient brings his or her concerns and symptoms to the GP.

Balint and his researchers estimated that around a third to half of patients in general practice presented with concerns that were emotional in nature or where physical health difficulties had an emotional component. They noticed that increased urbanisation brought with it fewer intimate relations for people Detached from their roots and separated from connections with their extended family; people experienced more solitude and found they had fewer people to seek advice and consolation from in their city neighbourhoods. Patients experiencing loneliness and isolation in this less connected urban context tended to visit the GP with more frequency. For Balint an explanation for this could be found in how emotional stress expressed itself. He argued that increased emotional stress, such as that derived from loneliness and isolation, can often be accompanied by increased bodily sensations and physical concerns. These concerns brought patients to seek out help from their GP with more frequency.

Later writers and practitioners have observed that this increase may also have been in part linked to shell shock and trauma during the Second World War (Paulsen, 2019). In other words, the impact of this trauma underlay some of the physical and emotional difficulties patients brought to the GP in the years following the Second World War.

Enid Balint (1979), writing about her experience of running Balint groups in primary care and hospital settings, described the kinds of questions and thinking that the groups made doctors consider.

Enid Balint (1979) wrote:

> *… in general practice, the questions the general practitioner has to ask himself are not only what illness is this patient suffering from, but also what (if anything) is wrong with him at this moment, other than his diagnosable illness and symptoms; what is he showing to me; or what is he trying to convey to me here and now; and finally, how can I help him? (1979, p.469).*

In 2020, Elders, writing about Balint groups describes how, in its first 30 years, the College of GPs was heavily influenced by the Balints' thinking.

Elders writes:

> *Many of its early luminaries had been members of groups led by Enid and Michael Balint. Their influence gave the new emerging discipline two main things: an exploratory, non-hierarchical group-based approach to training and a deeper appreciation of the GP's role as a generalist, and the significance of this within the structure of the National Health Service…. In the eyes of the College, a GP was above all a generalist, easily accessible to patients, relationship-based, and giving long-term continuity of care across the whole spectrum of illness. (Elders, 2020, p. 73)*

Following Michael Balint's retirement in 1961, for twenty further years the Tavistock ran weekly Balint groups as part of the General Practice training scheme. GPs (including Elders) were appointed as consultants in primary care to the Tavistock during the 1990s and 2000s.

In recent years, according to Elders, there has been increasing pressure on health and education commissioners to evidence the effectiveness of Balint groups before being able to introduce them. Much of recent research into the

effectiveness has focused on the benefits of the Balint Group using measurable outcomes often related to empathy. Elders argues that the impact of ‘major restructuring’ of health services both in the UK and overseas has shifted the focus of the groups to looking more at the impact of work stress and clinical work on the doctor.

The Balint Society is an organisation that continues to promote Balint groups and professional development in the UK and internationally. The groups still run in many countries supporting student and experienced doctors. The Royal College of Psychiatrists have made attendance of a Balint Group a mandatory part of training to become a psychiatrist (Elders 2020). In 2020, 15 UK medical schools had established or were developing Student Balint Group Schemes.

Alexis Brook, a psychiatrist, and psychotherapist, pioneered in bringing psychotherapy to general practice. He described his aim to help GPs ‘increase their skills in identifying and tackling the psychological problems they meet in daily life’ (Brook 1978).

Brook (1979) identifies the GP’s task as two-fold: to listen to what the patient is trying to tell him or her and to try to understand what the patient is causing him or her (the GP) to feel. Brook believed that the task of the psychotherapist in general practice is to support GPs in facing this major dilemma: ‘how to care for our patients while simultaneously having to cope with the patients’ anxieties but also those they rouse in us.’ (1979, p.467)

Brook (1979) identified how easily anxieties, difficult feelings and tensions between doctors and patients can influence the doctor’s decision making. Brook

uses the example of when a GP may consider referring a patient to a psychiatrist. The psychiatrist represents the need for support and thinking around mental health and emotional disturbance. Brook argues that a GP may refer a patient to the psychiatrist with the following aims: to provide specialist treatment, get expert advice, ‘to share the burden’ or ‘to be relieved of the patient’. Brook felt that sometimes patients were referred on prematurely to psychiatrists, when supportive and important work could be done by the GP with the patient. The difficult feelings and anxiety that a patient in mental distress stirs up in the GP can be behind these premature referrals to the psychiatrist, leading to frustration for both patient and doctor.

Parent-infant psychotherapy services were first established at the Tavistock clinic in 1975. In 1979, Dilys Daws began to write about her experience of setting up and running a child psychotherapy service in the baby clinic of a GP practice.

In 1979, presenting her work in the paper ‘Working as a Child Psychotherapist in a Baby Clinic’, Daws described the first three years of working with parents, babies, and clinicians in a GP practice. In the mid-1970s Daws proposed the establishment of a child psychotherapy service in a GP practice. Her thesis was that mothers of very new babies, perhaps particularly first babies, may have difficulties arising from their own personalities and experiences which affect their relationship with their baby. She hypothesised that these difficulties may show in the form of depression or anxiety in the mother and difficulties with sleep, feeding or other disturbed behaviour in the infant. She believed that some of these mothers and their babies could be helped by brief psychotherapeutic intervention and that ‘others could be helped by their own doctor or health visitor with the

support from the psychotherapist for the worker in confronting the degree of depression or anxiety being shown by the mother.' (1979, p.2)

Daws (1979) observed that there were many mothers who had not had any mental health difficulties at other periods of their lives but that the experiences of pregnancy, childbirth, and caring for the very new baby might throw them off balance. She imagined that these mothers 'in their vulnerability' would be receptive to supportive and interpretative therapeutic support.

Daws' paper on her work in the baby clinic captures the key features of Daws' model of working as a child psychotherapist in the GP practice. Specifically, she places emphasis on building relationships with health visitors, GPs, and practice staff, attending meetings, being present in the baby clinic, and being present and available to clinicians in the practice. She further emphasises the importance of being able to apply psychotherapeutic technique and thinking to a setting where she might be suddenly called to help a GP or health visitor in a consultation with a parent. She emphasised the value of supporting other practitioners to support the emotional needs of parents. She found that placing this emphasis on noticing and supporting the emotional needs of parents and their young children brought change in the staff group:

> *Over the two years, I have settled comfortably from being an outside expert, to be severely tested, to being one of the group, and psycho-dynamic interpretations, concern for the emotional side of a patients needs to not have to be left to me or attributed to me. (1979, p.5)*

Daws gives an example of how the child psychotherapist can support the GP or health visitor in their emotional work with parents and children when she

describes attending a meeting with the GP and a parent whose two-year-old child had died. The case had been before the General Medical Council (GMC) and a tribunal that had rejected the accusation of medical negligence. Daws describes listening with the GP for twenty minutes to the parent's painful story. She describes her understanding of why the parent felt able to speak about this in such detail on this occasion in the following way:

> *I felt that the fact that she chose this occasion to tell this story was partly because she knew him well enough to trust him with it and partly because my presence gave him a little extra support in receiving the pain. (1979, p.9)*

This account demonstrates the importance of the recognition of the supportive emotional role that GPs can play and the supportive role that the therapist can play in being open to the parent's experience and the practitioner's experience.

Daws describes her admiration for the health visitors' capacities and commitment to building and maintaining relationships with families with young children where there were high levels of emotional distress and complex physical, mental health and social needs. For instance, through working with health visitors she learnt about their experiences supporting parents who are managing developmental crises and disability in their young children and the impact this has on parental mental health and needs.

Daws (1985) and Williams (1981) describe the value of baby clinics in terms of supporting the concerns parents have about their small children. Williams (1981) writes:

> *Enthusiasts in the field of child surveillance point to the fact that all parents worry about their child's development and receive a great deal of satisfaction from hearing the doctor say he thinks the baby is developing normally. (Williams, 1981, p. 135)*

Williams (1981) and Daws (1985 and 2005) point to the social function of the baby clinic.

Williams writes:

> *I suspect for many mothers in urban areas, the clinic provides not just a source of help in dealing with the child …. City life fosters social isolation…. the solitary existence for mothers in high-rise flats all contributes to the loneliness, and where there is a lack of support in the home, the mother naturally turns to the primary care team for practical and emotional support. (Williams, 1981, p.137)*

Daws (1985) argues that it is imperative that we understand that the transference relationships that families have are not just to the psychotherapist but to the GP, health visitor, and the baby clinic and GP practice as entities in themselves. Where parents may struggle to speak about their worries and feelings of isolation and difficulty with their baby, they may manage to come to the baby clinic and seek support indirectly. For Daws, the transference relationship is not just to the therapist or clinician; it is to the institution, the baby clinic itself.

Henri Rey (quoted by Steiner 2012), a psychoanalyst working at the Maudsley Hospital with borderline and psychotic patients, referred affectionately to the hospital as 'the brick mother'. In other words, for these very unwell patients, their relationship was not only to the clinicians who treated them but to the hospital

itself. The hospital was like a ‘brick mother’ to the patients, like the GP practice and baby clinic, the building itself offered containment and support.

Steiner writes

> *Rey saw how important the hospital was as a place of safety for patients who were afraid of breaking down, and for whom it offered continuity and stability. (2012, Melanie Klein Trust website)*

In 1985, Daws published ‘Standing by the Weighing Scales’, a paper describing her therapeutic work with parents and infants in the GP practice. The paper described her consultative work with GPs and health visitors and stressed the value of observing parents and infants in the weekly baby clinic.

Daws makes an important distinction between working in one’s own institution and applying therapeutic techniques to working in the GP practice. She sets out some of the features of consulting to an institution other than one’s own. The consultant is an outsider; this can be uncomfortable for the GP practice staff but also for the psychotherapist. She compares this position of discomfort to that of an anthropologist carrying out fieldwork, where, without maintaining the participant observation stance, an important scientific perspective and a necessary distance is lost. Daws observed how important it is for the consultant to be visible and known to all existing and new clinic staff while maintaining the distance necessary to observe. She found that observing parents and babies and being close at hand to the clinicians in the baby clinic, was the optimum place for her to both be available to staff and to observe and keep in touch with the ordinary development of parents and infants.

For Daws, the structure around the parent-infant couple, the referral process, and the care provided to this family before they reach the parent-infant psychotherapy service play a vital role in helping the parent to be able to access help. Daws (1985), describes the referral process as vital in supporting parents and infants to seek help. If the referrer shows interest in the patient's concerns, listens carefully, and doesn't fend the patient off, the patient feels understood. For Daws, this sense of being listened to and understood helps patients take on psychotherapy and get a sense that the first person who listened to them, the referrer, is passing them on to someone else who will also listen to their concerns. This helps support a positive relationship for the parent towards help in relationships with baby clinic staff and the therapy service.

Through consultation, the referrer and child psychotherapist can look both at the problem the family present with and the clinicians' assumptions about why psychotherapy would benefit the family. This meeting also allows for discussion about the relationship between the referrer and patient. For Daws, this part of the consultation discussion is crucial as it provides an opportunity to explore the transference relationship. Questions such as: 'How does the patient relate to the clinician?' 'What feelings are noticed by the clinician in the presence of the patient?' can be asked. The descriptions of the relationship between the referrer and patient may give an idea of what the future transference relationship to the therapist may become. Furthermore, consultation with the referrer offers the referrer the opportunity to consider whether their discussion with the professional is 'a focus for cumulative anxiety'. In other words, if working with the family or parent and child brings with it high levels of anxiety, the consultation can help the

therapist and referrer consider what it might be in the family's history and presentation that stirs up anxiety in the referrer.

Daws (2005) describes consultation involving the psychotherapist judging carefully when to raise the anxiety levels about a family with the referrer and when to alleviate these anxieties. She believes that her role in the primary care team is to help the team identify the feelings aroused by patients in the clinician, and to help the clinician to manage these and, indeed, 'use them as a valuable source of information about feelings the patient might have and be unable to tolerate.' (2005, p.25) Consultation involves a process of listening and giving time to hear what clinicians have to say about 'problem patients', taking note of what is said and how it is said, attending to the feelings stirred up in one's countertransference and considering what these feelings can tell us about the emotional experience of the patient.

Much writing on the child psychotherapist's consultation in healthcare settings stresses the importance of multidisciplinary working. Ramsden (1999) writes about the 'clinical dialogue' between physician and therapist being an essential feature of work in healthcare settings where most child psychotherapists 'underline the singular importance of their relationships with colleagues' (Ramsden, 1999, p.22). For Ramsden, healthcare institutions are 'applied settings' which challenge child psychotherapists in many ways, taking the practice of child psychotherapy 'far out of its consulting room base'.

Hoag (1999) writing about the importance of the therapeutic frame when working in a GP practice describes the uneasy feeling and discomfort that can be aroused

> *…in the newly appointed therapist in relationship to the perceived power of the archetypal doctor who has life and death, sickness, and health in his hands. (1999, p.421)*

However, Hoag (1999) reminds us that GP practice clinicians must, on the other hand, deal with feelings aroused in them in the presence of a therapist colleague who works with the unconscious. She argues that the therapist working in the GP practice is seen as someone who can withstand and/or confront what the doctor and other surgery staff cannot. She refers to an interesting distinction made by the psychoanalyst Greeson in 1960 between inhibited empathy and uncontrolled empathy. The consultant, consultation, and supervision encourage inhibited empathy. This form of empathy allows a person to think, remember and interpret without getting involved with the patient in terms of affect. Unlike inhibited empathy, uncontrolled empathy can result in over-identification and acting out.

In a similar vein, Launer (2005) argues that to accept a psychotherapist in the GP practice means more than taking a new person into the practice. It is to accept that primary care patients have complex emotional needs and that primary care clinicians have learning and emotional needs too. For Launer the principal task of the psychotherapist in general practice is an educational one supporting primary care clinicians who are ‘in effect mental health workers’. GPs in this mental health role, provide support to patients, including and particularly to those who cannot be reached by other services. The GP practice offers easily accessible, long term, and in some cases, lifelong care and relationships between clinicians and patients.

Simpson (2005), writing about a pilot project introducing psychotherapeutic supervision to the work of health visitors advocates for the need for consultation and supervision for health visitors. The long-term nature of the relationship between health visitors and families (health visitors support children and their families up until the child's fifth birthday) and the complexity of the mental health needs of families, necessitate opportunities for health visitors to use supervision and consultation to think about these families and their work with them.

In his paper, 'From the Bridge', Kraemer (2016) describes therapeutic work in a healthcare setting. Kraemer stresses the support that families can feel when they witness professionals working together to understand, support and address their needs. He comments that one of the major challenges and most difficult transitions in healthcare is the referral on or handover of patients from one clinician or service to another. He argues that good consultation and multidisciplinary work support the needs of patients.

For Kraemer, this effective working together can be likened to Britton's concept of the achievement of a third position (1989). The third position marks a developmental point when the child is able to observe the relationship between two others and feel reassured that the parental couple can think about and make decisions about the child together.

The literature points to different psychoanalytic approaches that can help GPs, health visitors, and other professionals understand the emotional weight and challenge of their work. Salomonsson (2018) presents a strong argument for the importance of regular supervision for nurses and other professionals working in perinatal mental health settings. He describes his work providing weekly

supervision to nurses who provide care for a large caseload of parents and infants. Professionals can be on the receiving end of powerful projections of emotion from parents. Salmonsson writes:

> *The parent is at the end of her tether and wants to relieve herself of the qualms, anxiety and shame that weigh on her. She resorts to a mechanism we all use; we try to 'push' our distress into another person so that he may feel 'under the skin' what it is like to be helpless, hopeless, hapless.(Salmonsson, 2018, p.64)*

James and Rosan (2019) writing about baby clinics and the opportunities they present to support parent-baby relationships and professional relationships around babies and parents; argue that the 'weigh-in' at the baby clinic, 'can be a way-in to joined up physical and mental healthcare in baby settings' (James and Rosan, 2019, p. 400).

James and Rosan (2019), note how there are common concerns that parents bring to the clinic that could be addressed to a certain degree by group interventions, e.g., group support on sleeping and feeding difficulties. They advocate for a remodelling of the baby clinic by health visitors and practitioners to make them more 'relationally focused'. Drawing on their extensive experience of working with health visiting teams to remodel their baby clinics, they describe how in relationally focused baby clinics, parents and babies are encouraged to form a supportive group culture creating a sense of belonging. In relationally focused baby clinics, babies are spoken to and are valued as equal participants. In such clinics, health visitors feel more equipped to build relationships with families. James and Rosan advocate for reflective groups and trainings to be run by child psychotherapists or parent-infant psychotherapists.

Daws (2020) writes that a key task of consultation is to encourage practitioners to extend the scope of their work by adopting an observational, containing, thinking stance in their interactions with families, like that offered to them in supervision.

> *When they are confronting the symptoms described by parents in their babies, it helps them not to rush to offer advice and to reflect on the context of the problem itself. Instead of "Have you tried such and such?" Instead, they might say '"tell me more about it". I am encouraging them to be braver in letting patients talk about difficult matters, even in the limited time that surgeries allow. (Daws, 2020, p.110)*

Elders (2020) reminds us that the GP's task is fundamentally about dealing with 'whatever comes through the door'. The GP must deal with whatever comes her/his way and 'must decide what is treatable and what must be borne are managed'. The psychoanalytic psychotherapist provides what he refers to as 'psychotherapeutic listening'. The involves listening not only to patients but also to the primary care clinicians struggling with the complex physical and mental health needs of their patients and their relationships with them. For Elders, consultation works when the psychotherapist listens, tunes into the doctor's concerns, provides an exploratory attitude and only introduces ideas consonant with the doctor's own understanding of their role.

Psychoanalytic psychotherapists working in health and social care settings have observed the unconscious dynamics and processes that exist in organisations providing care for people who are vulnerable and traumatised. Turning to open systems theory, they have applied psychoanalytic understandings about how

distress is communicated and contained between patient and professional, to understand the dynamics that can emerge in relationships between patients and professionals and in organisations.

Writing about her work providing consultation to staff in a social care team, Sprince (2000) describes the role of the psychotherapist in understanding unconscious processes and their impact on the professional network.

> *In search of containment, looked after children project elements of their disturbance into the network around them as powerfully as they do in the consulting room…. child psychotherapists have an expertise that should help us make sense of that process…similarly our understanding of the unconscious interactions between children and parents gives us valuable insights into organisational dynamics. (Sprince, 2000, p.431)*

Armstrong (2005) writes about the transmission of emotional experiences through unconscious processes between members of an organisation.

> *Emotional experience is not, or is not just, the property of the individual alone; it is not located in a parallel individual space…. the emotional experience present and presented is always or always contains a factor of the emotional experience of the organisation as a whole, what passes or passages between members. (Armstrong, 2005, p.6)*

McLoughlin's (2010) concept of Circles of Containment describes her work as a child psychotherapist in a pupil referral unit (PRU). The involvement of the psychotherapist in the unit allows for circles of containment to develop around the young person. These 'circles of containment' describe a system in which the young person's emotional experiences are supported by meaningful contact with

practitioners thinking about his and his family's emotional experiences. This is achieved by the psychotherapist working in the unit with other practitioners and by providing the following interventions. Individual psychotherapy, parent work with the family, the presence of the child psychotherapist in the professional network meetings about the young person and by providing work discussion for PRU staff. To each of these, the child psychotherapist brings an empathetic and compassionate response, encourages it, and allows space to think about how to achieve this with others (parents and professionals supporting the young person).

These interventions allow for the powerful emotions projected by the young person and family into the network to be taken in, digested, and understood. This helps to create a deeper understanding of the emotional experience of traumatised children for the children themselves, their parents, and the professionals around them. It also helps the young person to feel understood.

Ansaldo (2021) reflecting on her work as a child psychotherapist in a specialist baby care unit (SCBU) observes that child psychotherapists notice and are engaged in the internal representations of the organisation for staff working in the unit. She writes that holding the 'organisation in mind' requires 'consideration of the multiple levels…. including the organisational and social processes that shape individual experiences.' (Ansaldo, 2021, p.1)

Clinical work in parent-infant psychotherapy

In 1941, Winnicott published his paper on the 'Set Situation'. The Set Situation drew on his extensive experience of paediatric consultations with infants and their parents in his clinic at Paddington Green Hospital. For Winnicott, these routine

consultations provided an opportunity to observe the internal worlds of infants and assess the infant's stage of emotional development. Winnicott's paper focused on the accumulated observations Winnicott made in his paediatric practice of babies aged between five and 13 months and their mothers.

The Set Situation describes a situation he routinely observed parents and children in his consultations. In this same paper, he outlines and provides case studies of what constituted a deviation from this. In other words, the Set Situation was observed under normal circumstances and a deviation would be, for instances, where the child's internal and external relations were affected by illness.

There were features and conditions that were consistent for each consultation. For instance, Winnicott saw families in the same large room on each occasion. The size of the room allowed him to observe the family entering the room and how the infant interacted with him and the parent. Consistent to each consultation were Winnicott's instructions that the parent hold the child on her knee and the placing of the shiny spatula on the desk in front of the baby. The setting, mother, family dynamics, the mother's approach to mothering, and the relationship between parent and child were also consistent factors.

Winnicott identified three stages in the interactions that would occur routinely with each parent and baby under normal circumstances. First, the baby would show interest in the shiny spatula. This would be followed by a 'period of hesitation' as the baby realised the situation required thought. The baby would then look to Winnicott's face and his or her mother's face. Winnicott noticed how if active reassurance was not given at this point, the baby would regain interest in the

spatula. In the next stage, the baby, reassured and showing interest in the spatula, would allow his feelings and desire for the spatula to grow. At this stage, Winnicott observed physiological changes, such as the baby salivating, indicating a desire to put the spatula in his or her mouth. At this stage, the baby might also delight in pretend play with the spatula, enjoying the adults pretending to feed the baby and be fed by the spatula. In the third and final stage, the baby would drop the spatula, initially without force and then with some force, banging the spatula on the desk or indicating he or she wanted to get on the floor with it.

In the Set Situation, Winnicott sought to use his observations of these common interactions to demonstrate the feelings babies may experience, such as anxiety and hesitation, and their external and internal relationships to others. For instance, the ‘period of hesitation’ is a moment where the baby demonstrates some anxiety about the spatula and how the adults will react, and the baby looks to their faces for reassurance or cues of what they are thinking and feeling.

For Winnicott, the relationship between parent and child was directly related to the relationship the child had with him or herself.

Winnicott (1941) felt that this set situation also gave important clues about the infant’s emotional development. The baby might show little interest in the symbolic possibilities of the spatula; in other words he does not connect the spatula to another human being. Or the baby may see the spatula representing something to do with his mother, for instance, with the mother’s breast. Finally, the infant may experience the spatula as representing a relationship between the doctor and his mother. Each of these responses gave clues about the infant’s

stage of development and the extent to which the baby was able to imagine and communicate his understanding of relationships.

In 1946, Melanie Klein described projective identification, a mechanism by which the mind splits off and projects unwanted parts of the self with the aim of protecting itself from overwhelming anxiety. These projections are wholesale and are designed to have an impact on others.

In 1948 Melanie Klein, referring to early infancy as a template, described the paranoid-schizoid position. This is a state of mind where paranoid anxiety about the survival of the self predominates. In order to survive, the infant in the paranoid-schizoid position, relies on defences of splitting and projection, projecting hostile feelings and unwanted parts of the self out and then fearing retaliation from these projected feelings. The development of the capacity to feel remorse, the wish to repair and to integrate loving and hostile feelings, marks, for Klein, the emergence of the depressive position.

Bion's (1962b) theory of containment explains the process by which a baby's distress is taken in by the mother who, in a process of reverie and thinking tries to understand her infant's distress. Through a process of introjecting, thinking about and putting this distress into a more digestible form, the mother helps the infant to feel that there is another mind trying to understand his or her distress. This, in turn, helps the infant to feel contained. Bion believed this same process took place in a psychoanalytic session where the analyst takes in, thinks about, contains, and puts into words the patient's distress. The patient communicates unbearable feelings, which are taken in and thought about by the therapist who tries to return these feelings in a more digestible form thus helping the patient to

feel understood. Bion's concept of containment is a theoretical concept which underpins some approaches to parent-infant psychotherapy and child psychotherapy sessions.

In 1975, Selma Fraiberg demonstrated the possibility of change and development that working therapeutically with parents and infants offers to parents, infants, and the relationships between them. In her ground-breaking work, 'Ghosts in the Nursery' (1975), Fraiberg and her colleague Shapiro describe their experiences of working with parents and infants in their Infant Mental Health programme. Fraiberg and Shapiro noticed how it is not uncommon in families, for 'ghosts of the past'; in other words, traumas, bereavements and losses in the parent's or the family's life and their emotional memory and impact to be reignited with the arrival of the baby. They turned to Freud's theory of repetition compulsion to consider this phenomenon. They noted that in some families the return of these 'ghosts' may be temporarily disruptive. For other families, professional help is needed to disentangle the emotional impact of memories from the past and the current relationship between parent and child.

Fraiberg writes:

> *Even among families where the love bonds are stable and strong…the intruders from the parental past may break through the magic circle in an unguarded moment…and a parent and his child may find themselves re-enacting a moment or a scene from another time with another set of characters.(Fraiberg, 1975, p.395)*

Fraiberg describes how for parents who have experienced significant early trauma, bereavement and loss, the child can come to represent a repudiated part

of the parent's self or figures of the past ('ghosts in the nursery'). The effectiveness of her approach derived from a strong underpinning of theoretical ideas that explained how the parent's projections skewed their perception of their baby and their relationship with their baby. Fraiberg and Shapiro inhabited two key positions in their sessions with parents and their infants which helped to disentangle the parent and infant from these threatening repetitions. First, they acted as the 'articulate spokesperson' (Fraiberg, 1975) on behalf of the infant. They did this based on close observation of the child and attempting to put into words what the child might be feeling, thinking, and communicating to the parent. Second, they created the circumstances under which a dialogue could build between the therapist and mother focusing upon the mother's present concerns but moving 'back and forth between past and present, between this mother and child, and another child and her family in the mother's past' (Fraiberg, 1975, p.395).

Fraiberg observed that the mothers she worked with were those whose 'own cries had not been heard'. Only once the mother's cries (her distress and pain from her own traumas and losses) were heard was the mother able to hear her own child's cries. This process of hearing, feeling, and acknowledging the mother's experience would then allow for improvements in the relationship between mother and infant to take place. An important feature of Fraiberg and Shapiro's work was that parent and baby were seen together. This was a new development in work with parents and infants and is an approach that continues to the present day. Where the parent's own distress feels too much or where the parent does

not feel comfortable speaking about their experiences in front of the baby, parents were and are seen on their own.

Miller (1992), like Fraiberg, emphasizes that the parent's perception of their young child often needs most exploration and support. It is this perception that stands in the way of the parent-infant relationship, hampering the kind of bonding and connection that is vital. By offering opportunities to think through and understand why a parent perceives their baby in a particular way and where these perceptions may come from (for instance traumatic experiences in the parent's own history), perceptions can change and the relationship between parent and child can get back on its developmental track.

Miller emphasises the urgency of parent-infant referrals. She writes: 'where the anxiety involves an infant or child, support is needed now…. the baby cannot wait!' (Miller, 1992, p.39) For Miller, to respond to the often-heightened level of distress in families at this early stage, under-fives services need to provide flexible, and responsive contact and adapt to the needs of young children and new parents.

The need for flexibility and understanding are factors that Ramsden (1999) considers paramount for child psychotherapists working in healthcare settings. She reminds us how families seeing therapists in healthcare settings may not expect to see psychotherapists. The physical health or medical needs are at the forefront of their concerns, not the emotional experience of being unwell or caring for a child who is unwell. Similarly, parents bringing their children to GP clinics may visit with concerns about complex health needs where the physical health need feels like the absolute priority. They too may not expect to see a therapist

or have the emotional experience of their or their child's physical health concerns in mind. This is another reason why the referral of parents and infants to therapy services need extra care and consideration.

Working as a child psychotherapist in primary care means working along the boundary between physical and emotional concerns. Tydeman and Kiernan (2005) cite a finding that one in ten children have emotional difficulties, 'often being expressed (and presented to the GP or health visitor) as physical symptoms rather than psychological ones.' In their research into referrals to a psychotherapy service in a London GP practice, Tydeman and Kiernan (2005) list the most common reasons for referral of children under five. These include sleeping, feeding, difficulties with separation, and toilet training. For Tydeman and Kiernan (2005) therapeutic work in primary care requires a flexibility of approach, a lightness of touch, and an ability to think quickly.

The urgency to see parents and infants is described across the literature. It seems to stem from two main factors: first, the vulnerability of the infant and parent to being exposed to and experiencing high levels of distress and disturbance in parental mental health; second, the urgency that stems from the emotional intensity at this early developmental stage that can be felt by families and by the professionals supporting them.

Schmidt-Neven (2005) writes that children's early years can evoke emotional intensity and turbulence in families. It is a time when external support is often needed. Schmidt-Neven found through her experience of running an under-fives service that it was not necessarily the therapist's insight that would help the child. 'Rather it is the therapist's ability to communicate with the parents in a way that

will facilitate the parents' own insight, which will in turn promote their relationship with their child.' (Schmidt-Neven, 2005, p. 191). She found that the most successful and enduring outcomes in work with under-fives are as a result of 'not only a shift within the child and the child's behaviour, but also an essential shift and change in the parents' perspective of themselves.' (Schmidt-Neven, 2005, p. 191)

Daws (2005) emphasises the risk posed to the infant, parent-infant relationship, and parent when the parent is struggling with postnatal depression. She describes how detecting depression in parents is not always straightforward. It takes a skilled, observant professional to notice depressed parents who can sometimes appear flat in affect and hide how they are feeling. Joint work between the referring professional and therapist can also help professionals detect depression in parents and support parents to receive appropriate treatment.

Emanuel (2008) describes the therapeutic process of working with parents and children under five as a 'slow unfolding at double speed'. The double speed refers to the surprisingly brief time period in which change can take place in parent-infant and parent-child relationships. Therapeutic work with parents and young children is complex, and a lot of attention is needed to allow parents and children to bring both the current difficulty (e.g., difficult behaviour in the child) and how it links to experiences in the parents' own histories. It is this unconscious link between past experience and the parent's perception of the child that disrupts the parent-child relationship and how the parent perceives their child's difficulty.

It is clear from the literature that therapists draw on different skills and techniques to allow for this slow unfolding to take place. Emanuel (2008, 2016) describes

how the therapist uses the experience and knowledge of infant observation, noticing the transference and countertransference and a knowledge of child development in order to support the family in the ‘here and now’ of the session.

Emanuel (2016) argues that when a child psychotherapist starts working in a GP practice, they cross a threshold from the consulting room and processes in CAMHS that they are used to a new setting and set of relationships in primary care. Yet, they still encounter all the challenges of under-fives work they are familiar with and trained to understand. The child psychotherapist draws on her/his training in infant observation, child development research, and psychoanalytic theory in this work. The child psychotherapist must also remain observant of and take careful note of the transference and counter-transference relationships that emerge between the family and therapist. However, working in a GP practice, the therapist is required to work in a more dynamic, spontaneous way, adapting to the needs of a busy primary care team. The therapist needs to be available at short notice to provide consultations to health visitors and GPs or join them in meetings with families.

Tydeman and Sternberg (2008) highlight an important dilemma that child psychotherapists can face working in busy primary care settings. They warn that the GP practice is a busy environment where ‘the clinician needs to be wary of premature interpretation’. (Tydeman and Sternberg 2008, p. 101). The busy pace of the GP practice and the heightened levels of anxiety in work with parents and infants in distress can make it difficult to work at the slower pace necessary for emotions and connections to unfold in psychotherapy sessions.

Urwin (2005) notes how across the literature on psychotherapeutic work with parents and children under five, there is a common agreement that there is significant potential for psychological growth, change and greater psychic flexibility in parents and their relationships with their children in the early years of a child's life. This seems to exist in parallel to the intensive growth and development that the young child undergoes in these intense early years (Barrows, 2008 and Miller, 2008, 2020).

Writing about change in psychoanalytic psychotherapy with under-fives and their families, Barrows (2008) draws our attention to the speed in which change can take place.

> *The Tavistock Clinic's Under Fives Service… offers up to five sessions, with change often apparent within the first few sessions, later sessions being provided to consolidate those changes. At times, such accounts can seem almost magical: the therapist is perhaps left in despair or puzzled – the family returns next time, and all is resolved! (2008, p.69)*

Barrows makes it clear, however, that this 'magical change' may be seen largely, in families where difficulties are not entrenched or complex and where families need a brief amount of support to help them back onto an ordinary developmental track. For this reason, Barrows (2008) writes that whilst there is significant evidence for the effectiveness of brief under-fives psychotherapy with parents and their children, for some families this is not sufficient. For instance, where trauma, bereavement, losses, and other complexities have deeply affected the parent and family, longer term work (like the work described by Fraiberg, 1975) may be needed.

Citing Daniel Stern's (1995) overview of parent-infant psychotherapy interventions, Barrows (2008) suggests some families referred to under-fives services may be best supported by 'serial treatment'. In other words, treatment may be more successful, and the family best supported by an initial period of brief under-fives psychotherapy with the possibility left open that they can return for further brief periods of treatment.

In her 2012 paper on Bion, 'Loss and the Anticipation of Loss in Under-fives Work', Emanuel describes in detail how the child psychotherapist pays close attention to unconscious communications between parents and therapist and unconscious communications between parent and child. She draws on Bion's model of containment, where the baby's communications of distress (described by Bion as the evacuation of 'beta elements'*)* are met by the mother's efforts to receive, understand, and think about what the baby may be feeling and experiencing. Citing Bion's concept of containment (1962b), Emanuel describes how this symbolic 'alpha function' of the thinking mother can, through reverie, help transform the emotional experience of the infant so that the infant feels both understood and knows the mother's attempts to understand his/her distress. The baby, in time, internalises this thinking mother and becomes more able to understand his/her own distress.

Drawing parallels with Bion's theory of containment, Emanuel demonstrates how, over time, families in under-fives services, who find their distress met with the attention paid to unconscious communication by a skilled and trained therapist; can experience change in their own perceptions, feelings, and thoughts about loss and themselves as parents. This transformation is made possible through

‘the introjection of a containing internal object through the process of maternal reverie and feeling held in mind.’ (2012, p.269)

Nathanson (2013) writing about her therapeutic work in a community mental health service for parents and infants, describes the importance of ‘third spaces’ in parent-infant psychotherapy. Third spaces can emerge in the therapeutic relationship over time and through the building of a strong professional network around the family to support the parent and child.

For Nathanson there are four levels of relationships which one interacts with when carrying out parent-infant work: the relationship with the referred family, the parent, the parent-infant relationship, and the relationship that the child psychotherapist builds with the network of professionals.

Nathanson observes how during a mental health crisis, the parent’s own anxieties and past experiences can get projected on to the infant and skew the parent’s perception of the infant and their own view of their parental capacity. Therapeutic work with parents and infants has two aims: to encourage the parent’s confidence in their own parental capacities and to encourage parents to observe and get to know their baby for who he or she is; a thinking and feeling being. The therapeutic process and relationship enable this to happen by providing containment for the parents’ anxieties, distress, and doubts.

Bargawai and O’Dwyer (2013), write about their experiences of child psychotherapy work in an inner-city GP practice. In this service, they were often referred parents who were both new to parenthood and new to living in the UK. They remind us that there are ‘many families who have experienced painful

losses, including the loss of their homelands.' (Bargawi and O'Dwyer, 2013, p.85).

Their paper presents the argument for the importance of holding a place in one's mind to consider the experiences and impact on families of trans-generational trauma, loss, and dislocation. Bargawi and O'Dwyer highlight the importance of sensitivity to these often-unspoken losses. In trying to relate to these losses and changes, they look back to their first moments working in the practice, themselves feeling new, uprooted and away from the familiarity of the Child and Adolescent Mental Health Service (CAMHS) clinic. In the CAMHS clinic, fellow clinicians are always close at hand and the boundaries and framework of therapeutic work in a clinic dedicated to psychological support help contain the difficult emotions and dynamics of clinical work.

Emmanuel (2016) and Sternberg and Tydeman (2008) warn that the demands of the high-pressure environment of a GP practice can leave the therapist feeling like he or she needs to come to conclusions and understandings about what the family are struggling with too quickly. Emanuel describes how a balance must be struck between being available, adapting to the pace of the GP practice and holding on to the gradual pace that allows concerns to unfold and emerge in psychotherapy sessions with families.

In her 2020 paper, looking back over the forty-year history of parent-infant psychotherapy work in the community and Tavistock clinic, Daws details the approach she takes to working with families. She describes working with families where there are difficulties with sleep with the baby. Daws explains how she takes the nature of the sleeplessness seriously. In so doing, she encourages the

parent to speak about the difficulty in their own way so that she can get a sense of what the parent makes of the problem and its origin. A secondary process that takes places concurrently involves her listening to the parent's emotion about the sleeplessness 'in all its intensity'. For Daws, feeling, getting a sense of, and listening to this emotion is a crucial part of the therapeutic process. The emotions that the parent experiences when his/her baby is not sleeping, is the emotion that the baby may be experiencing and picking up on from the parent during sleepless nights. Another important function of listening and feeling in this way is that it offers to the parents a sense 'that I am looking after them and the emotional intensity of the situation' (Daws 2020).

Daws (2020) describes how it is the minutiae of details of the family's lives that she is interested in. These details provide a vivid picture of the family's lives. She emphasizes that the unfolding of the family's story is a major part of the work. Offering a therapeutic space can be the first time that a parent has had the opportunity to speak about difficult things.

Miller (2020) writes that infancy and early childhood are periods of high-speed growth and development when 'much emotional heat is generated in the family'. In this paper she provides an overview of the history of child psychotherapists' work with under-fives and their families. A question that is often asked is why health visitors can't just support the issues that under-fives and their families bring to the health visitor. Miller addresses this question by pointing out that families referred to under-fives' services have all usually had thoughtful, intensive support from health visitors and it is only at the point that this support is no longer able to reach or affect the emotional difficulties in the family and relationships that

referrals are made to child psychotherapy. For Miller, families are best supported by under-fives services which work with flexibility, promptness, and informality. She argues that the depth of training and skills of the child psychotherapist makes it possible for them to support parents and their infants, where there are often high levels of complexity.

Training: the professional development of primary care clinicians in mental health

Much of the literature stresses the need for and importance of supervision, consultation, specialist training and continuing professional development for clinicians working with parents and infants in distress. In this section of the review, I am going to set out some of these recommendations from the literature. I will also refer to recent policy and commentary on this policy.

Launer (2005) writes that the majority of mental health care in Britain takes place in GP surgeries. Launer quotes research that reveals, as Balint did almost 60 years previously, that around a third of consultations in primary care are for psychological difficulties.

Elders (2005) describes how GPs play a key role in the maintenance of mental health. He argues that the collaboration that comes from psychotherapists being part of the clinical team has developmental benefits for primary care clinicians and therapists alike. Primary care staff are offered the opportunity to hone and develop their own psychological skills. Working in primary care, therapists learn first-hand about the challenges of primary care and the day-to-day mental health support that primary care clinicians provide.

Launer (2005), Elders (2005), and Bargawi and O'Dwyer (2013) draw attention to the accessibility of the GP practice. The GP practice is open and available to patients in its catchment area on a long-term basis. There are patients who need secondary mental health support but struggle to engage with services. The accessibility and familiarity of the GP practice and practice staff makes it possible for them to attend appointments with the GP or health visitor. However, this does mean that the GP is dealing regularly with patients with complex needs, without specialist mental health training on a long-term basis (Launer 2005).

Simpson (2005), a health visitor, designed and ran a pilot project looking at the skills health visitors use to support mental health in parents and children. Quoting an estimate that 80% of children with mental health needs do not reach specialist services, she highlights the need for specialist supervision and training for health visitors. Health visitors do not have formal mental health training and yet play key roles in supporting the mental health needs of parents and their children under five. Simpson also found that the role of the health visitor in supporting the family is often neglected in professional networks and planning meetings to support children. She gives the example of a young child who school and social services are concerned about. She asks, 'will anyone think to contact the health visitor who holds such important information about this child?' Simpson (2005) argues that the health visitor needs to be seen as part of the child and adolescent mental health (CAMHS) network, as a 'trusted professional who knows the intimacy of family relationships and the family home.' (Simpson, 2005, p. 143)

Simpson explains that health visitors have been trained to use behavioural interventions like the Webster-Stratton programme (a programme for parents that

aims to promote children's social competence, emotional regulation, and problem-solving skills whilst reducing behavioural difficulties, see Webster-Stratton, 2022 and 2007). Simpson argues that there is evidence to suggest the effectiveness of behavioural interventions. They increase parental self-esteem and empower parents to set clear limits, use non-violent discipline and recognise their children as individuals. However, Simpson argues, this training does not 'address in an exploratory way the emotional world of the child and the parent and the impact this can have on the worker' (Simpson, 2005, p.134). Furthermore, according to Simpson, for health visitors, training in behavioural programmes does not promote professionals working therapeutically. She argues that a therapeutic approach is necessary to deepen relationships with parents, engender trust and support parents to access further care.

Simpson's findings point to the need for the recognition of the health visitor's role in preparing families for referral to other services, such as secondary mental health or social care services. Her findings also highlight the value of supervision to support the anxiety involved in the complex work with families with mental health needs.

Writing about her consultation with health visitors, Daws (2005) describes what she believes happens when a health visitor is provided with supervision or consultation. Consultation and supervision provide opportunities to understand the transference relationships patients bring to relationships with professionals. She writes 'the health visitor who understands that a parent may be re-enacting the rejection she experienced in childhood will not be put off'. (Daws, 2005, p.27) She adds that it is often the health visitor who is key to supporting the family in

distress: ‘when families are in emotional trouble, the health visitor who already has built a relationship with the family through many meetings and much knowledge is in the best placed to help.’ (Daws, 2005, p.27)

In 2011, Edge, in a study of black Caribbean women’s perceptions of perinatal mental health care, discovered that black women of Caribbean origin rarely consult health professionals regarding symptoms of perinatal depression. Reasons for this are unclear, but Edge highlights the lack of perinatal mental health research with this ethnic group. She recommends that training for health visitors and primary care clinicians is informed by research that highlights disparities across ethnic and socioeconomic groups. She argues that it is vital to improve care for new parents and that the barriers that some groups and individuals face in seeking help are researched and understood.

In their 2018 edition of the Handbook of Infant Mental Health, Hinshaw-Fusilier, Larieu and Zeanah recommend three principles are followed in the training of professionals working in parent-infant mental health. They recommend that infant mental health training is relevant to the training of all professionals, that it is relevant to the ‘discipline of origin of the professionals’ and that its provision reflects the degree to which professionals are involved with infants, young children, and their families. They recommend that supervision and/ or consultation processes promote supportive relationships between parents and infants, parents, and professionals, and between professionals.

Elders (2020) argues the need to think about the current challenges of primary care when assessing primary care clinicians’ training and development needs. He cites a finding by Barnes and Hall (2008) that from the 1980s onwards, the

number of counsellors and therapists working in primary care increased steadily. According to Barnes and Hall's 2008 study for the Artemis Trust, by 2007, 88% of GP practices in the UK had access to practice-based counselling. Whilst there may continue to be counselling in some form in primary care, he writes many practices have experienced the 'slow loss of the therapist as an integral part of the team'. This is due to several factors, including more demands on the therapist's time to see more patients and to work across multiple sites. This makes them less available to attend team meetings and joint appointments with GP colleagues. Elders adds that changes in GP commissioning in recent years has impacted upon the GP practice's freedom to make referrals. GPs have less agency and power as secondary care mental health teams now hold more responsibility and power in terms of treatment decisions. This means that the GP practice has less say in the kind of mental health support offered to its patients and commissioning and budgetary decisions are made less and less by the practice themselves and more by secondary care teams.

Health visitors: policy and practice

In this section, I will provide an overview of some of the policies related to the mental health role and training of primary care staff.

The literature on policies about specialist training for health visitors and their role and responsibilities in supporting perinatal and infant mental health points to a very mixed picture. Whilst there has been a broad range of specialist training undertaken by health visitors across the country, there has also been a lack of formal recognition of the mental health role of health visitors (Lowenoff, 2017 and Barlow, 2022). Whilst there is a large amount of literature that points to strong

evidence bases for the broad range of therapeutic and mental health interventions that health visitors are trained in, I was unable to find literature that identified the percentage of the health visiting workforce trained in these areas. I found it hard from the literature to get a sense of how many health visitors felt competent about applying these trainings in their work with parents and infants.

Some of the literature points to a lack of formal requirements in terms of mental health training and a lack of formal recognition on policy level of the mental health role of health visitors. The literature highlights that there have been important and significant gains in recent years to acknowledge the pivotal and unique mental health role health visitors play. This includes the creation of Specialist Health Visitor in Perinatal Mental Health (Sp HV PIMH) posts and the Perinatal Infant Mental Health Champions (PIMCHs) programme. However, some research raises concerns about a lack of clear commitment from policy makers and commissioners to increase and formalise these specialist mental health roles for health visitors (Homonchuk and Barlow, 2022).

In 2014, the 1001 Critical Days Manifesto was presented to the UK parliament. It details how infancy can be a hard time for parents to access help but also represents a chance to effect change. Pregnancy and birth are critical windows of opportunity to support families when parents can be receptive to offers of advice and support. Pregnancy and birth are also times in the parent's and infant's life when they are most routinely seen by professionals. The manifesto outlines the evidence base for early intervention and highlights the importance of the involvement of local early services.

In 2020, the government commissioned a review of the impact of the plans set out in 1001 Days Manifesto. The findings pointed to the commitment of professionals working with families but identified that professionals do not always agree. They found that professionals do not always share plans of support with families, and they identified a need for the building of more professional networks of support around families. The report identified how some families lack confidence in local services and support and felt that it was not clear who is accountable at either a local or a national level for ensuring every baby is given the best start for life.

The report states:

> *The Review heard a great deal from parents and carers about the need for improvement; however, the Review also heard, loud and clear, a strong commitment from across early years charities, organisations, and the workforce to improving how we support families during the 1,001 critical days. (The Best Start for Life, 2020, p.7)*

Following this review, the government committed to six areas for action and improvement. These included providing more seamless support for families, clarity about the support available to families, improved access to Start for Life services, improved accessibility to information for families and better leadership in services.

The National Institute for Health and Care Excellence (NICE) published its guidance on Antenatal and Postnatal Mental Health: Clinical Management and Service Guidance (NICE Guidance CG192) in December 2014. Last updated in

November 2020, the guidance outlines the role of health visitors and GPs in supporting mental health in the perinatal period.

The 2014 NICE guidelines stress the importance of recognising parents' fears about seeking support during the perinatal period (pregnancy and a year following the birth). They emphasise that a common fear for women is that their baby may be taken away from them. The guidelines state that women with mental health problems may experience difficulties in the relationship with their baby. The guidelines require that the nature of this relationship, 'including verbal interaction, emotional sensitivity and physical care' is assessed and that women are encouraged to discuss any concerns they have about their relationship with their baby. They recommend that such an assessment provide information and treatment about the mental health difficulty and that further intervention to improve the mother-baby relationship if any problems have not been resolved, should be considered.

Commenting on the review of the NICE guidelines in 2014, Lowenoff et al (2017) note that maternal mental health is 'one of the six high impact areas designated to health visitors'. They also describe the unique position health visitors are in 'to fulfil the NICE guidelines and support prevention, early identification, prompt treatment and improved outcomes for mothers, their partners and their babies.' (2017, p. 1). Lowenoff presents evidence to support the key role that health visitors can play in the following areas of perinatal and infant mental health: prevention and early intervention, psychosocial assessment, assessing and managing physical and mental health, assessing the level of contact and support needed, facilitating access to integrated care, and promoting mental health.

She argues that health visitors occupy a unique position in supporting families due to both their training and the routine, regular contact and the kind of relationships health visitors can build with families. Health visitors have previous trainings in midwifery and nursing, they bring this knowledge, training, and an experience of routine assessment for mental and physical health concerns to their work with families. The relationship with the family and regularity of contact, puts health visitors in a key position to support families.

Lowenoff writes that health visitors are duty bound to contact the parent before birth (DoH 2014 and DCSF 2009) (2017, p.2). From this phone call a relationship can begin with the family and with it, the potential for a kind of ‘a therapeutic alliance using many of the common elements associated with effective psychological interventions such as empathy, warmth, genuineness, and mutual respect (IAPT 2010a, IAPT 2010b)’ (Lowenoff, 2017,p.2).

Lowenoff quotes studies by Gavin et al 2015 and O’Hara and McCabe 2013, that found that most new episodes of postnatal depression take place in the first three months of the baby’s life. Health visitors routinely see parents and their babies in the first six to eight weeks of life, so ‘the burden of this responsibility inevitably falls on health visitors as they are the only primary care health professionals who routinely see all mothers and babies beyond the first six weeks of a baby’s life.’ (Lowenoff, 2017, p.2)

Health visitors have the advantage of being able to meet parents in the safety and intimacy of the family home. This can make it easier to build trust and a relationship with parents. Parents are often fearful of disclosing mental health concerns, afraid of stigma and what may happen to their child if they disclose a

mental health difficulty. Lowenoff et al citing the NCMH (National Centre for Mental Health) 2014 report found that women are more likely to disclose mental health problems if they feel that they have a connection ‘with a single known health professional who is responsible for coordinating responsive, flexible and integrated care’. (Lowenoff, 2017, p.3)

Lowenoff et al (2017) argue that meeting families regularly makes it more possible for health visitors to undertake psychosocial assessments and begin to establish the nature of support that the family may need, and the level of support needed. Health visitors routinely take detailed histories of physical and mental health and social concerns. They also complete a family health needs assessment for every family on their caseload. This includes consideration of many of the factors that the updated NICE guideline (recommendation 5.4.8.5. NICE 2014a) recommends should be considered in the assessment and diagnosis of maternal mental ill-health.’

Health visitors are also, they argue, in an optimum position to identify ‘sub-clinical symptoms such as disturbances in sleep, appetite and concentration to understand the interplay between symptoms identified and the biopsychosocial consequences of motherhood.’ (2017, p.3)

> *For example, fatigue may be a symptom of depression, but it may also be a sign of poor thyroid function or anaemia, or disrupted sleep associated with infant feeding.*
>
> *Somatic symptoms such as back pain, headaches or nausea could indicate physical or psychological problems (Webb et al 2008, Harran et al 2014) or culturally acceptable ways of expressing emotional distress (Evagorou et al 2016).*

The NICE guideline states that most women with additional mental health needs will be identified and treated in primary care (NICE, 2014). The NICE guidance sets out the health visitors role in parental mental health, duties including liaison with the GP, referral to perinatal mental health services or IAPT (Improved Access to Psychological Therapies) mental health services, linking families to children's centres, groups, and community support services and, finally, offering therapeutic health visiting interventions.

In line with this guidance, health visitors use tools to assess mild to moderate mental health concerns. For instance, in all antenatal contacts with all families and contacts with all parents and babies within the first year of the baby's birth, the health visitor asks the Whooley Questions. The questions are two questions aimed at identifying symptoms of depression. They also complete the GAD-2, a measure for anxiety.

They may also complete, the GAD-7 (generalized anxiety disorder assessment), PHQ-9 (depression assessment) and Edinburgh Postnatal Depression Scale during contact with parents to getter a more detailed picture of the symptoms of anxiety and depression that the parent may be experiencing.

The list of therapeutic health visiting interventions that health visitors are trained in is extensive. They include non-directive counselling visits known as 'listening visits' or 'emotional well-being visits', group, or individual interventions such as infant massage, the Solihull Approach, the New-born Behavioural Observation Scale (NBO) and Watch, Wait and Wonder. These interventions aim to improve the parents' sensitivity and responsiveness to their infants. Health visitors may also have training in programmes including Incredible Years (Webster-Stratton

2007) to support parenting, emotional regulation, social and behavioural challenges in young children, Video Interactive Guidance (VIG) or ITSIEY (International Training School for Infancy and Early Years), a specialist perinatal mental health training run by the Anna Freud Centre and the Tavistock and Portman NHS Foundation trusts are two specialist mental health training programmes undertaken by some health visitors. The ITSEY training ended in 2021.

Here I will provide more detail about these interventions.

Until the review of the NICE guidelines in 2014 (Lowenoff et al, 2017), health visitor's 'listening visits' or 'emotional well-being visits' were included as one of the interventions that health visitors were responsible for undertaking with families. Listening visits are non-directive, counselling appointments for parents with mild to moderate mental health concerns.

In a 2010 study of listening visits, Segre et al found that in a study of 19 women with depressive symptoms, listening visits were associated with a 'statistically and clinically significant reduction in depression and improvement in life satisfaction' (2010, p.1)

'Listening visits' are carried out by the health visitor usually over four to eight visits. Training in listening visits vary across the profession (Lowenoff et all, 2017,p.1). The visits are aimed at helping the mother to gain a better understanding of herself and her circumstances in order to explore interventions or support that will help her to feel better (Cummings and Whittaker 2016).

Hanley (2015) in her manual 'Listening visits in perinatal mental health' describes how the approach taken in the listening visit is based on the clinical theories of Carl Rogers (1957). Rogers found that 'when his clients felt that their views were being acknowledged, accepted, encouraged and not judged, they thrived emotionally' (Hanley, 2015, p. 35). Hanley encourages health visitors to take an 'unconditional positive regard' of their patients and apply non-judgemental, open, empathic listening in their interactions with parents. Health visitors are encouraged to take note of and be aware of their own judgements and prejudices and to provide an open space for parents to express their feelings.

Hanley recommends the need for training, ongoing supervision and peer support for health visitors carrying out listening visits.

She writes:

> *Listening is a powerful, compassionate skill, but it is also complex and demanding…you will have spent an hour being attentive to someone else's need. Devoid of your own self-interest, you will shift between tranquillity and composure to stress and anxiety, as you try to make sense of and understand someone else's misery without absorbing all the emotional turmoil. Hearing, understanding and then feeding back are the key elements to the skill of listening……seeking help or supervision can help to restore your confidence or change your approach so that your level of stress is reduced. (2015, p.89)*

In 2016, Cummings and Whitaker undertook a quantitative study into the experiences of 33 health visitors delivering listening visits to women in the UK. The study found that health visitors widely used the intervention. These health visitors also reported that training in the use of therapeutic tools and wider

knowledge of mental disorders would improve delivery. Concern was also raised by the surveyed health visitors about lengthy waiting lists for mental health services. Long waiting times for mental health treatment, had sometimes resulted in health visitors providing listening visits to parents whose mental health needs had escalated beyond what the listening visit intervention could provide . Respondents also raised concerns about having an adequate knowledge of mental disorders.

A similar finding was described in Willis' 2018 review of listening visits. Willis writes:

> *Listening visits are often preferred by women, especially when delivered by an empathetic and intently listening health visitor. Listening visits also provide additional support for women who decline antidepressants, especially in areas with long mental health waiting lists. However, health visitors often feel ill equipped to provide listening visits in practice unless they have undertaken additional training. Guidelines and availability of providing listening visits also varies between clinical commissioning groups, which needs to be addressed. (2018, p.2)*

The Solihull Approach is a ten-week parenting group for parents with children aged 0-18 years who may have complex needs. The programme was initially devised by project groups of health visitors, child psychologists and child psychotherapists in response to a need for support with sleep difficulties. The approach is under-pinned by theoretical principles, research and approaches that support containment, reciprocity, and behaviour management (Douglas and Ginity, 2001, p. 222). Since the creation of the approach in the early 2000s, the programme has developed and been adapted to support children and families

with multiple and complex needs, including children with conduct and behavioural difficulties and special educational needs such as autism. The programme is delivered by two trained professionals from a wide range of professions and agencies through joint working and following a resource manual for parents with children. In 2009, the Solihull Approach was included in the NICE guidelines as a recommended parenting programme to support children with conduct difficulties (NICE 'Parent training/ education programme in the management of children with conduct disorders, NICE CG 158 on Parent Training programmes, 2009).

The evidence base for the Solihull Approach is strong. In an overview of research carried out by independent researchers (2022, available online), the Solihull Approach team, provide examples of over 40 pieces of published research and over 10 current research projects looking at the effectiveness of the approach. Undertaken largely in the UK, these qualitative and quantitative research projects range in focus and findings. Of the research projects focusing on the impact of the Solihull Approach on health visitors and the families they support, the following findings are of note:

In Douglas and Ginty's, 2001 study, 88% of health visitors reported increased job satisfaction, improved consistency in their approach with and confidence in their own skills with children and parents. In Douglas, H. and Brennan, A. (2004) preliminary evaluation of the Solihull Approach on children and families they found an overall decrease in parental anxiety of 66% amongst parents, significant reduction in anxiety relating to the problem that brought them to seek help and a

significant decrease in the severity of the problem (with their child or in the parent-child relationship).

Infant massage is usually delivered as a group intervention by early years practitioners of all kinds including breastfeeding specialist, midwives, and health visitors. Over the past 15 years, health trusts and community services in the UK have commissioned these infant massage groups for parents in the community to support parent-infant bonding. There is growing evidence to suggest that baby massage supports bonding and can support mothers with postnatal depression (Underdown, 2009). In a 2011 National Childbirth Trust research overview of interventions to support mothers with postnatal depression, they cite research from the first randomised control trial (RCT) to test the efficacy of baby massage. The findings of this study involving 40 parents and babies, receiving five, 75-minute sessions of baby massage instruction and practice, 'found significantly lower depression scores in the baby massage group and overall improved quality mother-baby relationships compared with controls' (NCT, 2011). Other studies have shown, infant massage positively affected the mood state of mothers in one randomized study, (Fujita et al, 2006 cited in Cooke, A. 2015) .Infant massage classes were found to provide a means of postnatal peer support, reducing isolation (Clarke et al, 2002 cited in Cooke, A. 2015). Finally, Onozawa et al, 2001, cited in Cooke A, 2015, found that infant massage has been shown to improve mother-infant interaction for mothers with postnatal depression in a randomized study. The limitation of some of these studies has been small sample sizes.

Brazelton's New-born Behavioural Observational (NBO) scale is a tool devised for health professionals working with parents and new-borns to encourage observation and understanding of early communication. The training provides professionals working with parents and infants, particularly where there may have been disruptions in attachment, e.g., through birth trauma or prematurity, to support early attachment.

Brazelton (1973) writes:

> *The Brazelton Behaviour Assessment Scale (now known as the NBO) is intended as a means of scoring interactive behaviour. It is not a formal neurological evaluation…. the main thrust of the evaluation is behavioural. It is an attempt to score the infant's available responses to his environment, and so, indirectly, his effect on the environment. (Brazelton, 1973, p. 4)*

Girling (2006) writes that the NBO can add value to assessments already being undertaken by health visitors and can contribute to partnership working between health visitors and parents. The observations encourage health visitors and parents to observe 'how the infant interacts with and organises his/her world'. Being trained in this observation tool enables health visitors to feel confident about demonstrating to parents their infant's strengths and abilities.

Girling adds:

> *This assessment has been shown to improve developmental outcomes by enhancing the infant-caregiver relationship and provide health visitors with the opportunity to consolidate their relationship of trust with families. (Girling, 2006, p. 118)*

Watch, Wait and Wonder is a child-led psychotherapeutic approach that encourages the parent to sit back, observe, and follow the infant or young child's spontaneous, free play. The intervention enhances parental sensitivity, responsiveness and understanding of the child's communication and sense of self. Muir, E, Lojkasek, M, Cohen, N (2002) found that this approach provides space for the infant/child and parent to work through relational struggles through play (2002, p.2).

2016 saw the formal creation and introduction of Specialist Health Visitor in Perinatal Mental Health (Sp HV PIMH) posts in mental health and the Perinatal Infant Mental Health Champions (PIMCHs) programme. Created by Health Education England, the publication 'Specialist health visitors in perinatal and infant mental health: what they do and why they matter', made the strong recommendation for at least one specialist in infant and perinatal mental health in each health visiting service (Rance, 2016). The posts would provide training and leadership roles in perinatal and infant mental health for specialist health visitors. The training for specialist health visitors provides enhanced knowledge and skills in areas such as the observation of infant development in the context of caregiving relationships, understanding the impact of intergenerational relationships and the development of healthy and disordered attachments. The first health visitors to take on these posts were based in CAMHS services in the NHS and had completed the Tavistock and Portman pre-clinical training in child psychotherapy, psychoanalytic observation course in the early 2000s. The Institute of Health Visiting provides further specialist training for health visitors in these specialist posts.

The Institute of Health Visiting are also responsible for the training of Perinatal and Infant Mental Health Champions (PIMCHs). The PIMCHs programme provides perinatal mental health training for health visitors and other practitioners working with children and families. The training 'provides the background and evidence to underpin a robust knowledge of perinatal mental health and illness for those who work with mothers and their families in the perinatal period, in order to become an advocate and resource for perinatal and infant mental health.' (Institute of Heath Visiting, perinatal training, 2022)

In January 2022, Barlow and Homonchuk published their report on Specialist Health Visitors (Sp HV PIMH). The background to this study was the 'context of diverging opinions about the need to commission this position' (Barlow and Homonchuk, 2022, p. 8). The researchers set out to find out the level of qualifications and training that sets these specialists apart from health visitors and perinatal mental health champions. They also wanted to answer questions raised about what makes the specialist health visitor's contribution unique.

Barlow and Homonchuk found that 0.8 % of the health visiting workforce are specialist health visitors in perinatal and infant mental health. An interesting finding given that most health visitors will encounter parents and infants facing mental health difficulties. Of the 34 SpHV PIMHS who participated in the study, 77% had completed a postgraduate certificate or diploma in a relevant mental health field, 29% had postgraduate degrees in community public health or psychological therapies. Eighty eight percent had completed Institute of Health Visiting mental health champions training, 65% were trained in the Solihull Approach and 12% had completed the ITISEY training at the Anna Freud Centre.

The study found that whilst specialist health visitors occupied leadership roles with strategic, governance, service-redesign and supervision responsibilities, the perinatal mental health champions carried an almost full caseload with some protected time for liaison with perinatal services. They found that two-thirds of respondents reported having a small caseload of families with more complex mental health needs (69.6 percent). Seventy four percent had a caseload of under 100 families and a typical caseload consisted of 15 to 20 families with complex problems.

Barlow and Homonchuk (2022) and Lowenoff (2017) raise concerns in their reports about the commitment from commissioners and policy makers to the role and place of health visitors in supporting perinatal and infant mental health. Homonchuk and Barlow 2022, estimate that the cost per cohort of babies per year of perinatal mental illness is £8.1 billion.

Barlow and Homuncuk write:

> *Specialist health visitors in perinatal and infant mental health constitute just 0.8 % of the health visiting workforce and this appears to reflect an ambivalence on the part of policy makers with regard to the development of specialist roles generally within health visiting, and a lack of clarity about the role and funding in terms of the commissioning of such posts more specifically. (Barlow and Homonchuk, 2022, p.3)*

Lowenoff et al (2017) explain

> *We will illustrate the part that health visitors could play in preventing, assessing, and managing maternal perinatal mental health problems. However, it must also be acknowledged that there are a*

> *number of contextual factors, such as changes in commissioning and organisational priorities that mean that health visitors are not always able to fulfil this very important part of their role. (2017, p. 2)*

They continue to highlight how the national initiative to increase the number of health visitors between 2011 and 2015 (Department of Health 2011) by 50% has been threatened by further cuts in funding in public health. The impact of this being that health visitors continue to carry heavy caseloads and do not have time freed up to provide more intensive support for families with identified additional needs. Lowenoff et al warn that the delivery of the NICE recommended levels of perinatal mental health information is put at risk amidst budget cuts, service restructuring reorganisation and conflicting policy priorities.

The need for specialist provision in mental health amongst health visitors, the challenging conditions of changing commissioning plans, and increased workloads are themes that also emerge in the literature on the role of GPs and their training in mental health.

In a 2008 report published by the Royal College of Psychiatry, recommendations were made that psychological therapies should be delivered by a psychologically minded and trained workforce. The report recommends that GPs have more influence over care pathways, and more training to develop therapeutic skills. They state that primary care teams need resources to become more psychologically minded.

Writing in 2020, Elders describes how the links between primary care and psychotherapy have changed significantly.

Elders writes:

> *Since the 1990s health services in most countries have been subjected to a series of organisational reforms and upheavals that have affected morale and the role of professionals in a fundamental way.*
>
> *Balint's original aim of a limited but considerable change in the doctor's personality'(M. Balint, 1957) is more difficult to accomplish with the reduced frequency of Balint groups…. and where there is a widespread concern about the state of professional morale with high rates of illness and burnout (Kjeldmand, 2006).*

In the 1970s, Launer established the Tavistock Community Unit made up of GPs, social workers, adult, and child psychotherapists working in community and primary care settings. Whilst the Tavistock no longer has a primary care consultant or department, it has extended its reach out into GP practices to establish the Team Around the Practice service (TAP) in the London borough of Camden and the City and Hackney Primary Care Consultation service (CHPCS).

TAP ran for ten years between 2009 and 2019. It aimed to support GPs to manage patients with 'complex mental health and other needs that result in frequent health service use, pressure on general practice, over investigation and iatrogenic risks' (Kent, 2017). The service supports patients with 'medically unexplained symptoms', personality disorders, and chronic mental health problems. Many of these patients also have psychiatric co-morbidity and may have poor physical health. The project provided training, consultancy, joint appointments and case-based discussion to GPs and practice staff.

Both the TAP and CHPCS services provided psychoanalytically informed supervision and treatment. They also offered patients a range of other treatments and activities. These included systemic therapy, couples therapy, group therapy, mentalisation, and social activity groups including photography and gardening. The service was commissioned repeatedly over a period of 10 years but in 2019, the decision was made not to recommission the service.

With aims similar to those of the TAP service, the CHPCS was initiated by a group of GPs in collaboration with mental health experts at the Tavistock and Portman. The CHPCS aimed to reach patients with mental health problems that could not be managed through existing primary care services and who fell outside the scope of other local mental health services. In an evaluation of the service Carrington and Rock (2012) found that the service improved health outcomes, lead to a reduction in health service use in primary and secondary care services and the service brought a two third reduction in patient treatment costs. It also had a very high satisfaction rating amongst local GPs. Seventy five percent of all patients showed improvements in their mental health, wellbeing and functioning as a result of treatment.

Carrington and Rock (2012) report:

> *It was estimated that treatment by the PCPCS reduced the costs of NHS service use by £463 per patient in the 22 months following the start of treatment. Savings in primary care accounted for 34% of this total (mainly fewer GP consultations) and savings in secondary care for 66% (fewer A&E and outpatient attendances and inpatient stays). Just over a third of the overall fall in service use occurred while*

treatment was in progress and the remaining two-thirds in the following year. (2012, p.18)

Conclusion

In this literature review I set out to cover and include references to literature that describe and demonstrate three aspects of the psychotherapist's work in general practice: consultation, clinical work and supporting the professional development of primary care clinicians. I also aimed to look at relevant policies and demonstrate the training provision, needs and gaps in provision of services and training for health visitors and GPs. This literature review sets out to address a gap in existing literature reviews which tend to focus on either the clinical approach or the application of psychoanalytic ideas to work in primary care but do not consider the training and development needs of primary care staff.

No research study, that I am aware of, has yet taken place that looks at the contribution of child psychotherapy to clinical work carried out by GPs, health visitors and child psychotherapists in a primary care setting.

Chapter 3: Methodology

Introduction

In this chapter, I will describe the methodology I employed in this research project at different phases and stages of the study. I will provide a description of the aims and design of the research project and the recruitment process. I will provide a detailed overview of the data collection and data analysis processes and how I came to the final selection of themes. I will also explore considerations around validity and ethics.

This research study was designed with the aim of collecting and analysing data that might provide insight into the contribution of child psychotherapy to understanding, supporting, and treating early distress in new parent and infants.

This research study took place in a GP practice where a consultant child psychotherapist, Dilys Daws had established a child and parent-infant psychotherapy service, consultation and supervision of health visitors and GPs in 1976. Forty` years later, she continued to run the service in the practice one day per week. Over the past 10 years, Daws had been joined by trainee child psychotherapists on rotation; each placement lasting 12-18 months at a time. The consultant child psychotherapist and the trainee provide treatment, consultation and training to the GPs and health visitors supporting parents and infants.

In the introduction to this study (pp.18-24) I provide a detailed description of the service and setting.

Aim of the research project

The primary aim of this research project was to explore the contribution that a child psychotherapy led parent-infant psychotherapy service has made in supporting parents and infants in distress. This research study was designed with the aim of collecting and analysing data that might reveal what it is that child psychotherapy might contribute to understanding, supporting, and treating early distress in new parent and infants in a GP practice.

A secondary aim was to find out more about how health visitors and GPs approach supporting parents and young children where there are emotional difficulties. I aimed to look at the parallels, commonalities and differences in approach and understanding that health visitors, GPs and child psychotherapists bring to this work with parents and their young children.

In the GP practice, the child psychotherapist offers consultation to health visitors and GPs about mental health and emotional difficulties faced by some parents and infants in the early years. I wanted to find out what this form of consultation may provide to support GPs and health visitors' clinical work with parents and their young children and their understandings of the emotional experiences of parents and their infants.

In this research study it was viewed that the best way to explore those aims was through looking at two types of data:

- The first set of research information would come from data collected from semi-structured interviews with clinicians (such as GPs, health visitors and child psychotherapists) on their experiences of working

with parents and infants. Through interviewing clinicians working in the GP practice, I hoped to understand their experiences of and perspectives on working with parents and infants with emotional difficulties.

- The second set of research information would be collected from the detailed process notes from psychotherapy sessions with parents and infants. These would be detailed notes that I had written that recorded in detail the process of the psychotherapy sessions with parents and infants. The notes would be written up after the session and provide examples of child psychotherapy work undertaken in the clinic with parents and infants. I believed that these notes could provide information about the emotional difficulties faced by parents and their children, their perspectives on these, insight into the child psychotherapists' perspectives on this clinical work with families and direct examples of the process of psychotherapeutic work to support them.

3.1 Choice of research methodology

When designing this study, I considered both qualitative and quantitative research methods. One quantitative method I considered was using questionnaires. I considered writing and distributing two questionnaires surveying the experience of clinicians working with parents and infants with emotional difficulties and a second, to be completed by parents receiving support for emotional difficulties. One of the advantages of a quantitative approach would have been that the questionnaire could have been distributed to a larger sample size of participants. However, I felt that there were limitations to this approach that would make it difficult to reach the aim of this study. Looking in detail at the experience of parents and infants and professionals was a central aim of this

study. A questionnaire might allow me to ask a wide range of questions about personal experiences, but the answers were likely to be limited and it was difficult to imagine how it might be possible to gain in-depth details from people answering the survey. I was interested in learning about the experience of clinicians and parents and decided that a questionnaire would not have allowed space to gain sufficient insight into their experiences.

The subject of the research study is a highly sensitive one and a questionnaire to parents about their experiences of emotional difficulties in early parenthood posed the risk of causing further distress to parents by asking about mental health concerns. I ruled this out on ethical grounds.

Qualitative research uses investigative methods, such as unstructured or semi structured interviews to gain insight into the experiences of a group of participants. Such methods allow the researcher to explore a case study which deepens our understanding and brings authenticity to the material.

As Willig (2013) describes:

> *Even though we do not know who or how many people share a particular experience, once we have identified it through qualitative research, we do know that it is available within a culture or society' (Willig, 2013, p.17).*

Qualitative approaches to research aim to collect data which can lead to new findings that were not hypothesised at the start. These are explorative methods that allow researchers to look at the data without pre-established theories that need to be falsified. The strengths of qualitative research include its effectiveness

in collecting data from a ‘local population’ (in this case, the clinicians, parents, and infants) and in providing complex textual descriptions of how people experience a given research issue (Mack, 2005).

Semi-structured interviews are optimal for gaining insight into individuals’ personal perspectives, experiences, and relationships, particularly when sensitive topics are being explored. Semi-structured interviews offer effective ways of collecting open-ended data, opportunities to explore participants’ thoughts, feelings and beliefs and can allow for in-depth exploration of personal experiences. Commonly used in qualitative research and the most frequent qualitative data source in health services research (DeJonckheere M. and Vaughn, L.M. 2019), this research method involves a dialogue between researcher and participant, guided by a flexible interview protocol and questions. The semi-structured interview also offers the potential for free association.

I considered using Thematic Analysis, Grounded Theory, and Interpretative Phenomenological Analysis (IPA) to analyse my data.

When thinking about the interviews with clinicians, my first thought was that analysing the data using thematic analysis might allow me to identify patterns and themes common to the experience of all clinicians interviewed. However, applying Thematic Analysis felt limiting when I considered using it to analyse the data from process notes of sessions with parents and their children and in meeting my aim to understand the experience and perspectives of clinicians on their experience of supporting parents and infants in emotional difficulty. My aim was to gain insight into the experience of both clinicians and parents and their

young children and how they made sense of their experience. thematic analysis did not feel like the appropriate methodology to try to meet this aim.

The ultimate aim of Grounded Theory is to create theories that can explain the phenomena analysed. My aim was not to develop theory but to learn more about the experiences of clinicians, parents, and their young children. So, on this basis I decided against using Grounded Theory.

IPA aims to consider how participants make sense of their personal and social worlds by looking at the meanings that experiences, events, and situations have for participants (Flowers, Larkin, Osborn 2012). I felt that using IPA to analyse the data would help draw out the experiences of parents and clinicians. I hoped this analysis would provide insight into their perceptions and how they make sense of their experiences.

IPA uses a double hermeneutic process which invites the researcher to find out more about how participants make sense of their world and offers up the opportunity for the researcher to interpret how participants make sense of their world. I felt that this approach, while labour intensive, would provide a focus on the experience of participants, helping me to remain attuned to my aim of understanding the perceptions and points of view of the participants.

3.2 Access and recruitment of the samples

I recruited two different sets of participants for this research study: families who had been referred to the parent-infant psychotherapy service and the second

group were clinicians (GPs, health visitors and child psychotherapists) working in the GP practice baby clinic.

Recruitment of families

The GP practice is an NHS organisation. The parent-infant psychotherapy service, whilst based in the GP practice for over 40 years, is a service provided by the Child and Adolescent Mental Health (CAMHS) service of an NHS mental health foundation trust. I sought and received ethical approval for this study through the NHS ethical approval process (IRAS) prior to recruitment. I sought and received approval to undertake this study by the GP practice and the mental health trust. In the study protocol I described how I would recruit patients to ensure that their confidentiality was protected and that the recruitment to this study took ethical considerations into account at all times.

Exclusion criteria

Before commencing the study, I set out my exclusion criteria for recruitment. Exclusion criteria for families included families where the parent or child were already receiving mental health treatment elsewhere and where the child or parent's mental health needs were complex. The rationale behind this decision-making was ethical, practical and in line with the criteria for referrals to the service. The service does not take on parents and children who are receiving mental health treatment elsewhere, so that excluded parents and children receiving mental health treatment elsewhere automatically. From an ethical perspective, I wanted to ensure that parents felt entirely free to decide whether they wanted to consent on their own behalf and on the behalf of their child. I felt

that asking new parents with complex mental health needs to consider taking part in the research study was unethical.

Other exclusion criteria included: serious concerns around developmental delay in the child; severe parental mental health difficulties that required urgent specialist treatment; domestic violence; neglect or where there where child protection concerns. The rationale behind these exclusion criteria were similarly related to the needs of the families. Where there were serious concerns around developmental delay, the parent-infant psychotherapy service would not take the referral but would support the GP or health visitor to signpost the family or support a referral to the local child development service. Finally, if there were safeguarding concerns around harm, neglect and child protection, and risk was high of harm, I decided not to approach these families to participate. This was both an ethical decision and one based on the immediate needs of the family. It felt unethical to ask a family in this level of need and distress to spend time considering taking part in a research project. Also, where there were safeguarding concerns, the service would refer to social care and whilst the service might continue to work with the family in some capacity, the urgency for safeguarding support must be of highest priority. Where there were safeguarding concerns, the health visitor and GP would follow safeguarding procedures and usually remain involved in the care of the family.

Where there are complex mental health needs, parents may need to be referred to adult mental health services by the GP or health visitor. Under such circumstances, the child psychotherapists will discuss the case in detail with the GP and health visitor to support the referral to adult mental health services. The

aim is always to try to continue to support the family and transfer them carefully to other, more suitable services.

Procedure

I set out to recruit a maximum of four families and a minimum of one family to the study. In this study, family was defined as a parent or parents and their child (where the child was aged under five years old). In all instances, there may be older children in the family. To be included in the study, families needed to be registered at the GP practice and to have been formally referred by letter to the parent-infant psychotherapy service. Children needed to be aged between one week old and under five years old. The referrer needed to have met with the family on at least two occasions before the referral to assess, amongst other things, the mental state of the parent and child and to rule out and assess other needs.

The families who were approached to take part in this study were all patients (both parents and child) registered at the GP practice. They were all patients who had been referred to and had started treatment in the practice's parent-infant psychotherapy service.

I wanted to ensure that families were well informed about the study, felt they had time to consider taking part and the possibility to ask any questions about what taking part in the study would entail. It was vital that they felt they could decide in favour or against taking part and were confident that their decision would have no bearing on their treatment.

As the lead child psychotherapist and I were the therapists that the family would see for treatment, it was important to ensure that the recruitment of participants was kept as separate as possible from the psychotherapy treatment. In so doing, I hoped to ensure that families did not feel under any pressure to take part in the study. I thought carefully about how to minimise the risk of parents feeling under pressure to take part in the study. Completing the IRAS ethical approval application for this study and discussing the application with the IRAS local ethics committee, gave me further opportunity to consider how to minimise this risk. The committee agreed with my suggestion that the risk might be minimised if another clinician working in the service presented the opportunity to participate in the research study to the parents.

The procedure for inviting parents and their children to participate took place in the following way. Families were referred to the service in the usual way. After the second psychotherapy session, families were invited to meet with a trainee child psychotherapist to receive information about the study. The trainee child psychotherapist had six years of clinical experience in the NHS and was familiar through her training as a child psychotherapist with research ethics, methodologies, and protocols. I briefed her in detail before she met with families and provided her with information about the study, information sheets, and consent forms for families.

During her initial meeting with the family, they were provided with information about the study and the opportunity to ask questions. They were asked to consider taking part and asked to return the consent form to the trainee child psychotherapist within the next two weeks if they decided to participate. All

potential participants were provided with an information sheet which included details of who to contact if they had questions or concerns about the study. During the meeting they were verbally informed of the information detailed on the information sheet. They were also given the consent form.

The information sheet provided details of what participation entailed. During the meeting with the family, the trainee child psychotherapist explained these details to the family.

It was made clear to the parent that participation was entirely voluntary, had no impact on treatment, and that parents could withdraw from the study at any time before the data analysis (one year on from recruitment) without providing an explanation. Information sheets detailed who the family could contact if they had any questions or concerns about the study and provided details on how their confidentiality and data would be protected (see Appendix One).

In the recruitment of parents and their infants to the study, when families where both parents were involved in the life of the child were approached, we asked that the parents speak to one another and agree consent between them about participation in the study.

Three families were recruited to take part in the study: one single-parent family and two two-parent families. For two of the families, the referred child was their first child. All recruited parents and children were of White European (not British) ethnicity. In the case of all three families, it was mainly the mothers who attended the parent-infant psychotherapy sessions. In two instances, they attended with their infants. Two of the infants recruited were aged between six and nine months

of age. One of the children was two years old. All the parents were aged between 30 and 35 years old.

In two families, both parents were from different countries: both parents had grown up outside of the UK and did not have members of their own family of origin and extended family living in the UK. The parents had all lived in the UK between five and 15 years and in two instances, the families had lived in more than one country other than the UK before moving to the UK.

The mixed, international backgrounds of the recruited families and their experiences of having lived in more than two countries, was, in fact, representative of a number of families who were referred to the service. These families were often living far away from typical support structures that new parents and children rely on including communities of family and friends. They were relatively new to the UK health and social care system and some of the concerns they described in sessions were related to the stresses involved in being at a distance from families, making choices about which country to live in and the isolation and unfamiliarity they experienced in becoming new parents in a relatively new home.

Table one below provides details of the families recruited to the study:

Age of child	Presenting concerns	Frequency	Number of sessions	Session analysed

Three	Separations and toilet training	Weekly	Five	Three
Five months	Family disruption and behavioural difficulties in older sibling around arrival of baby	Weekly	Five	Three
Six months	Parent feeling desperate when baby cries, parent feeling isolated and low.	Weekly	Six	Three

Table 1: Recruited families

The GP practice and its baby clinic are located in a highly ethnically and socio-economically diverse inner-city area. The practice population reflects this. All the parents who participated in this study were non-British nationals and they had moved to the UK within 15 years of the study. They were all raising children away from their families of origin and were all from different cultures to the British one where child-rearing, physical and mental health practices and understandings differed. In two cases, the mother and father were from two different countries and different cultural heritages.

Recruitment and selection of clinicians

I set out to recruit a selection of clinicians who were representative of the range of professionals that parents and their young children meet at the baby clinic and

GP practice. This range of professionals includes child psychotherapists, health visitors and GPs. I decided that the selection of clinicians needed to include a representative of each of these three professions. In addition, the clinicians needed to have regular contact with parents and infants and to have experience of referring parents and infants to the parent-infant psychotherapy service and/ or receiving consultation support from child psychotherapists working in the parent-infant psychotherapy service.

The clinicians were recruited initially by sending an email with details of the study and participation. With the GP practice manager's consent and assistance, this email was sent to all GPs and health visitors working at the practice. This included an email flyer detailing the study I was undertaking inviting clinicians to contact with me if they were interested in finding out about the study and taking part. Clinicians from both professions work on rotation in the baby clinic of the practice and the email reached 12 health visitors and 15 GPs.

I was contacted by three health visitors and four GPs interested in taking part in the study. The health visitors who approached me had between four months and over five years' experience of working at the baby clinic in the GP practice. One of the health visitors was responsible for running aspects of the baby clinic. Three of the GPs had worked in the practice for over five years, two had worked in the practice for a period of between 10 and 20 years, one of the GPs was newly qualified and in the first year of working in the GP practice at the time of interview. Following the same recruitment procedure for health visitors and GPs, the consultant child psychotherapist who had worked at the practice for over 40 years

and a trainee child psychotherapist were approached to take part in the study by email.

I provided each clinician with an information sheet detailing the study and they were asked to sign a consent form by email. I offered to make myself available to answer any questions about the study and taking part. Consenting to the study involved agreeing to commit to an hour-long, semi-structured interview to provide data that would be anonymised. It involved agreeing to share thoughts and reflections on their work with parents and infants in distress.

Greenlagh (2019) stresses how qualitative research emphasises the importance of interviewing in a natural setting. I chose to interview GPs and health visitors in a private consulting room at the practice. Interviews lasted up to one hour and were recorded using a recording device. In total, I recruited nine professionals.

Table two below shows their professional backgrounds.

Profession	Number
Child and adolescent psychotherapists	One
Trainee child and adolescent psychotherapists	One
GPs	Four
Health visitors	Three

Table 2: Professionals recruited

All but one clinician (the newly qualified GP) was female and aged between 35 and 55. All of the GPs were White British; two health visitors were Black British, and a third health visitor was White British. Both the child psychotherapist and trainee child psychotherapist interviewed were White British.

3.3 Data collection

I collected two forms of data in this study: detailed process notes of psychotherapy sessions with parents and their children and recordings of semi-structured interviews with clinicians. In this section, I will detail how I collected these two data sets and how samples were selected for this study.

Process notes

Following each psychotherapy session with the families participating in the study, I wrote up my session notes in detail. In order to ensure that I had enough time and could fully apply the thorough analysis required in IPA, I decided on a sample of one session per family. The session I selected was the third session in treatment for each family. By the third parent-infant psychotherapy session, usually the therapist and parent have developed an understanding of what the main concerns are for the family, and the family history and an understanding is developing of the relationships between parent and child and between the family and the therapists. Sometimes, the third session can feel like a mid-point in the therapeutic work. The Tavistock model of psychoanalytic psychotherapy with under-fives (as described in Emanuel 2008) is a five-session approach where the five sessions may form a treatment in themselves or become an assessment for further psychotherapeutic input. This informed my decision making to select the

third session in the treatment for data analysis. For each recruited family, I analysed the process of the third parent-infant psychotherapy session with the family.

In Table One I provide an overview of the families recruited, the age of children and their presenting concerns. In all three sessions, the consultant psychotherapist and I were present. In the case of two families, Sara, and Ronan and Helena and Maria, the parent and baby attended the psychotherapy sessions. In the case of Hayley and Chantal, the parent attended this session on her own. Pseudonyms were used in the writing up of my process notes and here in this thesis. The families' details have been fully anonymized and, in the process notes and details of the families changed to protect their confidentiality. These are my process notes of my sessions with the parents and their children, so the reflections and observations are my own.

The process notes of psychotherapy sessions are written shortly after the session. They are a detailed account written by the psychotherapist of her/his observations, what was said by the family, what is said by the therapist, the feelings conveyed, and any countertransference observations from the therapist. Capturing as much detail as the therapist remembers and with as much accuracy as possible, the notes can then be looked at to gain a better understanding of what may have been communicated by the family and to gain deeper insight into the emotional difficulties experienced by the parent(s) and child.

Following the sessions, I wrote up my notes in as much detail as I could remember. I aimed to provide as much detail as possible of the process of the

session, my countertransference, the details of what was said by therapists and family, and the observations I made during the session.

The challenges of self-disclosure are present in both forms of data collection. Early on in psychotherapy sessions, parents may not yet feel able to put into words or express their feelings and thoughts. It takes time and the development of a therapeutic relationship and trust for patients to feel they can speak openly.

In interviews with professionals, I anticipated that whilst there may be some comfort, familiarity, and trust due to the fact that they were familiar with the parent-infant psychotherapy service, I was also aware that I was interviewing them in their place of work about their work and that this may mean that this might limit their self-disclosure.

Semi-structured interviews

Once the participants had agreed to be interviewed, I arranged to meet them at the GP practice. I wanted to meet them in the most natural setting and in a room that was both familiar and comfortable to them and where privacy would be possible. I met the GPs in their own consulting rooms, the therapists in the therapy room and the health visitors were provided with a room within their service area in the practice to meet me in.

Prior to the interview, the clinicians had received the consent form and information sheet. Before commencing the interview, we went through these in detail, and discussed how their data would be stored and how confidentiality

would be protected. Once they had signed informed consent, then the interview commenced.

I devised a study protocol made up of nine questions for the semi-structured interviews (See list of semi-structured interview questions in Appendix Two). These questions aimed to explore the experiences of clinicians working with parents and infants where there were emotional difficulties. The questions sought to find out what they notice about their work with parents and infants in distress, how they approach this work and what prompts them to consider making a referral to the parent-infant psychotherapy service. They were open questions that would allow for further exploration.

I undertook nine interviews. All lasted between 40 minutes and one hour and ten minutes. Interviews with the GPs and health visitors with less experience of working in the baby clinic were shorter. In most instances, the questions were a guide, and participants had a lot to say about each area of interest, often using the question to link to other interesting perspectives, accounts of experiences of work with parents and infants and their own feelings and experience of the work and their roles.

Interviewees were encouraged to give examples of and speak about the following areas (the full list of questions can be found in Appendix Two):

> *The clinician's experience of working with parents and young children who came to them with emotional difficulties.*
>
> *Their view on the common emotional difficulties parents and young children seek help for and what they feel they do that helps.*

What they notice about the emotions that parents and their young children convey and what they feel the biggest emotional challenges are that parents and young children face.

What situations/ observations might prompt them to make a referral to the parent-infant psychotherapy service.

What they feel helps them to support parents and infants in distress and their views on what further support would help them in their work with parents and infants where there are emotional difficulties.

All interviews began with the same first question, asking the participant to speak about an example of working with a parent and infant/ young child where there were emotional difficulties. This was a very interesting question that, on each occasion helped to launch the interview into further important areas of interest. I wanted to keep the interviews as open as possible, allowing the clinicians space and time to speak freely and openly and make links between their professional work, their experience of it, what they made of these experiences and the feelings and perspectives this work has brought them.

This work with children and families can be very emotive, and it is notable how frequently the participants referred to the powerful feelings they experienced doing it and the vivid and rich descriptions, expressions, and tones of speech they adopted when speaking about this work. In most of the interviews, the participants gave at least two examples of supporting parents and young children where there were emotional difficulties. This suggests that it was commonplace for the clinicians at this practice to encounter, notice and often speak and think with parents about emotional challenges in the early lives of their children.

In each interview, I covered the questions planned, but having less than ten questions allowed for enough time for both questions to be answered and for the participant to follow new trains of thought. It also gave me the time to ask additional questions to follow up a new line of enquiry, an interesting theme they were exploring, or to ask them to clarify and explain further about points they had made.

I recorded the interviews using a recording device and transcribed them myself.

I listened to each recording at least twice before deciding on which interviews to select for data analysis.

Sampling

Purposeful sampling is used in qualitative research for the selection and identification of information-rich cases and examples. As I wanted to get an in-depth view from a small sample of clinicians who work in the baby clinic, I chose this sampling technique. Citing Creswell and Plano Clark, (2011) Palinkas et al (2015) describe purposeful sampling as involving 'identifying and selecting individuals or groups of individuals that are especially knowledgeable about or experienced with a phenomenon of interest' (2015, p. 533). It was also important that the clinicians were willing to participate and articulate their views in a detailed, expressive, and reflective manner.

In purposive sampling, preselected criteria relevant to the research question guide the sampling, and sizes are determined by the resources and time available as well as the study's objectives (Mack 2005). According to Mack, the purposive sample size is often determined based on 'theoretical saturation' (the point in the

data collection when new data no longer brings additional insights to the research question).

Selecting my sample of interviews was a difficult process as each interview was rich with information and detail. Given the size of this study and the resources I had available, I decided that sampling one interview for each profession working in the baby clinic would be representative and provide a wealth of material to analyse. The main guiding principle and selection criteria for sampling became based around the professional with the most and most recent experience of working in the baby clinic with parents and infants and seeing parents and infants in the GP practice. An additional criterion for sampling was that the clinician was familiar with making referrals to the parent-infant psychotherapy service and/or receiving consultation from the service.

I undertook, recorded, and transcribed nine interviews and listened to each in-depth. I looked at the interviews in this preliminary way to see what themes were emerging. Considering the time required to analyse each interview using IPA, I took a sample of three interviews, one to represent each of the professions working in the baby clinic. Following the completion of the theme-gathering stage of the IPA analysis, I then listened to and looked back at all of the interviews and looked for striking examples that brought the themes to life.

While this was a change in the study design, it was a pragmatic decision that allowed me to analyse material from both data sets and complete the study. The implication of this study redesign is that I had fewer samples of GP and health visitors to draw on. The other interviews were rich with data. I made my selection based on the clinicians with the most experience and the most recent and current

experience of working in the baby clinic and with the parent-infant psychotherapy service to refer parents and their children for therapeutic support.

3.4 Data Analysis

In this section I will outline the data analysis process, how I used IPA and detail the three phases of data analysis I undertook.

Flowers et al. (2012) believe a rich IPA study comes from identifying with and empathising with what participants speak about whilst trying to make sense of how these individuals construct meaning within their social and personal world. IPA's theoretical commitment to seeing a person as cognitive, linguistic, and affective gave me confidence that this approach would help provide a holistic view of the experiences of the families and clinicians who participated in this study. IPA assumes a connection between what people speak about and their thinking and emotional state. The methodology encourages the researcher to interpret aspects emotion and state of mind from what is said. This has parallels both with the psychoanalytic approach and seemed to fit well with the data I planned to analyse.

During my first attempts to think about the data I had collected, I imagined that the experience of parents and their young children and the experiences and perspectives of clinicians could be neatly separated out. In other words, that the data could be organised around the descriptions of experience linked specifically to being a parent and separately, themes linked to being a professional. As the analysis progressed, it became clear that there are many parallels and

crossovers in experience between the two participant groups. Separating out the themes and experiences according to the two participant groups, was to miss out on a great wealth of data. The data analysis revealed that there are a lot of commonalities in the care-giving role and responsibilities of parents and the emotional experiences that come with this, and the care providing and giving roles of GPs, health visitors and child psychotherapists supporting parents and infants.

The data analysis took place over 48 weeks and in these phases:

Phase one: Transcription of interviews, process notes and diary keeping

Phase two: Line by line analysis of interviews and process notes

Phase three: Coding and noting of emergent themes from analysis

Phase four: Emergence and selection of themes

Phase one: process notes, interview transcription and diary keeping

The transcription process was a rich one. During the transcription of the interviews, I was guided by the principles of IPA that Smith, Flowers, and Larkin (2012) recommend. These included immersing myself in the data, keeping a broad and open view and not coming to any interpretations at this first stage of data analysis. I used a research diary to note any interesting thoughts and impressions that stood out as I listened to the transcripts. This helped to both bracket off any early interpretations and to help me move away from the psychoanalytic approach to interpretation that I was used to. The diary also helped me to stay immersed, curious, and interested in the richness of the data.

During this stage, I took the following approach with considering the process notes and starting the analysis. I read through the notes three times, making diary observations and notes as I did so, trying to keep as open a perspective as possible. The main challenge of analysing process notes using IPA, is that psychotherapists are used to looking at notes and making interpretations. In this instance, I was challenged to try to look at the data without making interpretations. I include below notes from my diary entry about one of the three sessions to illustrate this process.

Session three: Sara and Ronan – 3rd listen

How does she/ they feel about the GP practice?

Noticing how baby looks around and with recognition.

Baby has big eyes and looking, lots of mention of the baby looking to professionals, away from mum, sense of him wanting to hold people with his eyes.

Remembering this big baby with blonde hair in detail, looks older and bigger than he is. My feelings of shame about not warming to this baby.

Hold on to horrid feeling of how big and desperate this baby feels.

Repetition of desperation, desperate feelings, something, and someone feeling too big and too much.

Figure 1: Research diary entry listening to session note Sara and Ronan

I transcribed the interviews and began to make initial notes in the following way. First, I listened to each interview twice without making any notes at all.

On a third listen, I used my research diary to note any feelings, sensations, any changes in pace, tone of voice, expressions and to generally make note of the atmosphere/ sense of the interview and what the interviewee seemed to be conveying. I used the diary to capture my own reflections and thoughts as I listened. At this stage, I was simply curious about first impressions and capturing in the transcript as much detail as possible. Through using the diary, I hoped to keep as open an approach as possible to the data being collected.

On the fourth listen, I began to type up what was being said, pausing often to capture accurately what was being said and including changes in tone of voice, expressions, pauses, and working out a common way of recording these. I found it helped to transcribe the interviews in chunks rather in one go. Whilst this was a time intensive process, I took this approach in order to ensure accuracy and achieve a true representation of the interview.

Figure two shows some of the notes from my research diary about one of the interviews.

Recording of GP interview, third listen.

Emphasis placed on emotional/action words, e.g., 'I HATE', 'I feel', 'they exude stress', 'frustration',

Lots of mention of 'worry'

Lots of language that conveys knowledge, e.g., 'we know how stressful it is',

Keen to connect to my questions

It is stressful for everyone when the birth is traumatic – lots of deep breaths, stumbling and faltering speech here.

Lots of vivid descriptions, really conjures up a very vivid, direct, stark image in my mind, e.g., cold hands on warm baby's skin

Note the change in pace, the sense of urgency and fast pace when speaking about worrying situations and emergencies

'I am medical, and I care about my work, and I am also defensive' – words that came to my mind when she describes feeling she has to defend her profession and decisions when parents are in great distress.

Figure 2: Diary extract based on listening to recording of GP interview

Phase two: line by line analysis

IPA is 'characterised by a set of common processes (moving from the particular to the shared, from the descriptive to the interpretative)' (Flowers et al 2012).

The first stage of analysis involved looking at the transcribed interviews and process notes, reading these through three further times and keeping notes in my diary as I did so. I then created a document with a table divided into three sections with the headings Emergent Themes, Original Transcript and Exploratory Commentary (I enclose an example of this in the appendix three) for each interview and each process note. I pasted the interview transcript, or the process note transcript into the middle column. I left the section Emergent Themes for the time being, and I focused on the commentary.

There were six pieces of material to analyse (three session notes, three interviews). I first analysed the interviews then the process notes, one at a time, completing the analysis of one before moving on to the next.

With the interviews and process notes, the initial set of notes I made were descriptive and maintained a focus on capturing the participants' experiences and the meaning of these for the participant. With the interview transcripts and process notes I found it most helpful to follow a key focusing on three areas whereby I noted the descriptive comments, focusing on the content (in normal text), linguistic comments on how the participant spoke (in italics) and, finally, conceptual comments (underlined). In both the analysis of the process notes and interviews, expressions which were powerful and conveyed strong emotion or were confusing, uncertain, and quite thought provoking stood out. In analysing the process note material, the material that stood out most and the material that I felt drawn to comment on and think about in detail were observations I made and the descriptions of my countertransference. I also noted at this stage, how in some of the interviews and sessions the pace changed. I found it particularly interesting how changes in pace of speech or emotion conveyed stood out. I listened out carefully for these moments and spent a lot of time tracking these shifts in emotion and pace in both the interviews and process notes. For instance, these shifts were at times characterised by a powerful emotion, such as anger or anxiety being conveyed which then shifted to something calmer, more thoughtful, or quite confusing or empty.

There was a temptation to gather up conceptual comments too soon; however, simply noting ideas, theories, and concepts in relation to what was being said

helped me to slow down the process and keep a broad and open perspective and mind. The process was a very gradual one which required looking at excerpts, expressions and observations in detail and depth. Through approaching it this way, I felt that a deep analysis could be achieved by maintaining an open mind and noting these powerful or quieter or confusing/unknown moments in as much detail as possible. Making detailed notes and reflecting on these helped me to really explore and focus on what might be at the heart of the experience being described by the participants.

Expressions, use of language, the pace of speech, pauses, changes in speech with a powerful emotional underlay, or quieter moments where the tensions in the interview or psychotherapy session changed or dissipated, were very interesting to consider. I also found myself focusing for some time on certain expressions, taking time to explore what the meaning might be of these. Frequently, interviewees and the parents and infants and psychotherapists (myself and my colleague) would use very striking turns of phrase and sayings.

For instance, in her interview the health visitor described the complex situation that can occur when parents are insistent on weighing their babies too frequently. She spoke of over-weighing being a ‘double-edged sword’. She was speaking about a difficult situation to negotiate where she must find ways to reassure anxious and insistent parents about the weight and health of their baby and explain why it is not recommended to weigh babies too frequently. During the analysis of this material, I found myself exploring in my comments the definition of this expression and what this saying might mean in this context. I also noted the stark contrast between what is described in this expression namely a double-

edged sword, something sharp, dangerous, and frightening, and the context in which it is being used in reference to vulnerable parents and babies. I was interested in what the expression might mean to the health visitor when professional and scientific guidelines may conflict with the anxiety, insistence, and distress of parents. Looking at the process notes from the psychotherapy sessions, I often noted how powerful my own countertransference was at the start of the sessions, even before the parent and child arrived. The feelings I had in anticipation of the session and the powerful feelings and states of mind conveyed by parents and infants on arrival at the sessions were rich and I was drawn to look at them in depth to note what was being said, how it was expressed and what might be the concept underneath. I often was not sure yet what the concept was or what was being conveyed about the parents', infants' and therapists' experiences, but taking time to look at what I had written about the session in detail, helped concepts and ideas to formulate.

Phase three: coding and noting emergent themes

My first step in coding or noting emergent themes was to review each interview document and each process note document and record in the first column the emergent themes. These were generated from both the exploratory comments and the interview transcript itself. I allowed the emergence of the themes to be guided by what was striking.

Some of the themes themselves were phrases taken verbatim from the interview transcript, for instance '*they just exude stress!'* This was an example where the sounds of the words alone conveyed the intensity and tension of the high levels

of stress that the clinician was describing in parents who are struggling with anxiety with their babies.

Similarly, the themes that emerged from this phase of analysis of the process notes were expressions taken directly from the session notes. They were often linked to intense emotional communications either by direct speech or from the countertransference I recorded in the notes. For example, a parent was speaking about her own fears for the future and her fears that her daughter would not grow out of the toileting difficulties she was experiencing. The emergent theme I recorded was *A terrible fear for the future.*

Once I had followed the same process for each of the interviews and process notes, I colour coded each interview. Colour coding meant that I could colour code the font of each interview and copy and paste the final emergent themes for each interview or process note into a document each. The total number of themes from all three interviews analysed was 161.

Phase four: emergence and selection of themes

The next phase of data analysis required me going through the 161 themes and noticing where there was repetition. In this initial phase, I reduced the themes to 78. The next phase involved noting common themes and beginning to cluster themes together. By keeping the themes colour coded according to the interview or process note they belonged to, I was always able to trace the theme back to its original source.

As I immersed myself deeper and deeper in the data, allowed myself to get lost, frustrated, uncertain of what I was doing, I found gradually that I was more able

to see patterns and groups of themes. I presented my first set of themes to my supervisor who encouraged me to keep going and not to get to the grouping of themes and collections of themes too quickly. The longer I looked at the data, the easier it became to refine the themes as they now appear in the findings chapter.

3:5 Ethical considerations

To ensure I considered all ethical implications in the design of my study, I completed the NHS Health Research Authority application and received approval for the study a year before data collection commenced. I also completed a module in Research Ethics at the University of East London in 2017.

I followed the guidance and requirements of the NHS Health Research Authority (HRA) during the year before data collection commenced. I completed the HRA Integrated Research Application System (IRAS) application, and formal ethical approval for this project was granted by the HRA in August 2017 (see letter in appendix four). As part of this process, I was also required to attend and present my study to a meeting of the HRA local Research Ethics Committee (REC) in June 2017. Here, I both presented my study and sought the guidance and recommendations of the committee, taking their recommendations to inform the finalized and approved version of my ethical approval application. One of the questions that the panel helped me to consider was how to approach patients to participate in this study in the most ethical and sensitive way possible. It was following my meeting with the panel that I decided to design my protocol so that a trainee child psychotherapist would introduce the possibility of participating in the research study to families. This approach was aimed at reducing any pressure

that the families might feel to participate in the study, something the panel felt would have been harder to ensure if I (the clinician seeing the family and the author of the study) had spoken to the families about the study.

Whilst interviews with clinicians do not require ethical approval from the HRA, I still detailed my ethical considerations and used the IRAS process to carefully consider and detail my considerations around ethics for the inclusion of clinician participants in the study.

The IRAS process and designing the research protocol of this study, meant that prior to starting the study I did a lot of thinking and preparation and sought guidance from my research supervisors, my university, and the NHS trust I was working in. My main considerations were around how to ensure participants had enough time and information in order to decide about participating in the study, to allow for informed consent, and to prevent patients feeling under any duress or pressure to take part. As I was planning to recruit families to the study during the period I was working in the parent-infant psychotherapy service, this meant that the participants in this study would be patients I would be seeing for therapy. This presented a challenge I had to think carefully about.

The main initial challenge I faced was how to recruit families for the study without being involved in the information giving and recruitment process itself. I did not want patients to feel there was any pressure to take part in the study and felt that if I was to discuss the research project with them, whilst also being their therapist, they may have found it difficult to feel free to make the decision themselves. This issue was resolved by a trainee child psychotherapist agreeing to meet with the families to discuss the study and invite them to participate in the study.

Other challenges I felt were found in the experience I had with seeing the families whom I recruited to the study in therapy. I had to think carefully and use my own reflective practice and supervision to consider carefully whether the fact that the family agreed to take part in my study had an impact on how I spoke to them and interacted with them. I sometimes found myself questioning if, out of gratitude for them taking part, I felt less able to be direct and still help them to think about painful and difficult experiences. I tried to keep an eye on this and realized that seeing the families with the consultant psychotherapist helped me to feel confident that I was able to speak to and work with the families in the necessary therapeutic way, still able to be direct where necessary and help them to think about painful truths. Something that is so central to this kind of therapeutic work.

I was guided by principles of Respect for Persons, Beneficence (minimising risk) and Justice (as detailed in the 1974 Belmont Report on research ethics). The ‘Respect for Persons’ ethic relates to ensuring that participants’ autonomy and confidentiality is respected, and where participants are vulnerable, particular care is taken to protect this. Working through the IRAS application and designing my study, I demonstrated how I would respect both patient and clinician participants by ensuring that they had adequate information about the study and that they were aware of how their confidentiality would be protected. Through my information sheet, consent form and the initial contact about the study with families and clinicians, potential participants were informed that should they decide to leave the study at any point before the data analysis, they would be free to do so without having to provide any explanation.

As the study involved families, parents, and young children, it essential to consider the vulnerability of these young children and the fact that they could not verbally consent, and that consent was being sought on their behalf. To this end, I stated clearly on the consent form that the parents were to consent on behalf of their child and where there were two parents in the family, they were encouraged to consider taking part and their child taking part together. Offering a first meeting with the trainee child psychotherapist and then giving parents a period of time (between this meeting and the next appointment at the service, up to two weeks) to consider and discuss taking part, I felt allowed parents to consider carefully what it meant to take part. In terms of vulnerability, it is important to note that I also carefully considered the exclusion criteria for this study. I did not recruit families where there were complex mental health or social care or physical health needs in parent or child. Therefore, questions of capacity to make informed decisions were avoided.

In terms of the recruitment of clinicians, prior to recruiting clinicians, I wrote to the lead GP at the practice and sought and received consent for the data collection to take place on their premises with their staff team. I also met with the lead GP, lead health visitor and a second GP who had over 20 years of experience of working at the practice and in the baby clinic to explain my research proposal and to provide an opportunity for them to ask questions about the study and for me to seek their guidance. They were also informed of the study through the information sheet and consent form and they consented to me contacting the staff working in the baby clinic. I discussed with them issues around vulnerability and the emotive nature of the interview material to ensure that they felt that the study was

something their staff would have capacity to do and felt comfortable with participating in. As with the patient participants, clinicians were given consent forms, information sheets and I spoke to them on the phone initially about the project, giving them two weeks between the phone call and our next contact to consider whether they wanted to take part. They were also made aware that they could withdraw from the study at any point before the data analysis without explanation.

In terms of risk, neither the patients nor the clinicians were at any risk of physical harm taking part in the study. However, for clinicians, the topics being discussed in the interviews were of an emotional nature and posed the risk of some distress to the clinician. I informed clinicians at the start of the interview that they could pause or stop at any time and offered a follow up meeting if wanted. There were decisions I made about the inclusion of sensitive information. My approach to this was to choose carefully which interviews to include in the study. I wanted to protect confidentiality fully and also felt ethical decisions had to be made about what was perhaps too exposing and personal to include in this study. For instance, during an interview, a GP spoke in detail about personal experiences that I did not feel would be ethical to include so I excluded this interview from the data.

The families referred to the service who decided to take part in the psychotherapy sessions were aware that the sessions in themselves could be emotionally challenging. Families were given opportunities to ask questions, were provided with information, made informed consent, were given time to consider taking part, and knew they could withdraw from the study at any point before data analysis.

They were also provided with contact details for myself, the researcher and my institution and research supervisor.

Participants were informed that all names and details of the families, clinicians, the clinic, and its location would be anonymised. The information sheet detailed how I would follow data protection requirements and that all data would be stored on a home computer (not one that I would transport) under password protection and all consent forms would be kept in a locked security box.

3:6 Reflexivity and validity

While I acknowledge and appreciate how my personal experiences have shaped my professional work, it has also been very important for me to be able to separate out my personal and professional experiences. To this end, I reflected regularly on the feelings this project stirred up in my own supervision. I also took particular care to ensure that I noted down my countertransference experiences in a research diary after each interview and in the process notes.

In the session notes I did include my countertransference but carefully interrogated these in myself to reflect on what was an emotional communication from the parent and child and what might be related to my own feelings. This is standard practice in child psychotherapy. However, I was particularly careful when writing up these session notes. Keeping these notes separate helped to bracket these thoughts and reflections and allow the opportunity to return to them later. This kind of separation is an important feature of both psychoanalytic clinical practice and qualitative research.

| was surprised by the feelings and thoughts I was left with after the interviews. The interviews with health visitors and GPs alike were full of powerful emotions. I realised during the process of data collection that the GPs and health visitors have few opportunities to speak about their work, to reflect and speak about the emotional experiences of their patients and the impact on them. Work in the GP practice is fast-paced. GPs see patients for 12-minute appointments. For health visitors, there were more opportunities to meet together to reflect as they had some reflective practice through termly supervision groups at a mental health trust. They also held a debriefing meeting after the baby clinic sessions to discuss families they were concerned about. However, I also learned that around the time of my data collection the health visitors were facing a restructure in their service and the weekly baby clinic debriefing meeting for health visitors was on pause at the time.

It was important to keep in touch with the lead health visitor, GPs, and lead child psychotherapist throughout this time to be aware of what was happening in the practice and baby clinic and the potential impact it had on clinicians and their own experiences.

On reflection, being a familiar face to the GP practice staff and being familiar with the baby clinic and GP practice, may have both helped and hindered the research project. I had worked in the baby clinic for one morning a week for 18 months before my data collection began. I had provided consultation to and discussed families with health visitors and GPs and had seen them weekly in the baby clinic and the informal coffee meetings where GPs and health visitors often discussed families. This may have encouraged clinicians to consider taking part in the

interviews. I realise now that recruiting four very busy GPs who were willing to be interviewed for an hour demonstrates the support and the value, they see in the service too. I felt that in the interviews the GPs and health visitors felt comfortable discussing and disclosing aspects of their work that were challenging and painful. I think speaking to someone who is interested professionally in the emotional worlds and experiences of others, certainly must impact upon the kind of material and themes that the participants discussed in their interviews.

This was the first time I undertook semi-structured interviews as a researcher and as a child psychotherapist. I wonder if the free-associative aspects of the semi-structured interview, the topic and question may have helped to provide the conditions for professionals to speak openly about their experiences.

Throughout this project, I remained committed to and actively tried to notice, note, and interrogate my emotional reactions, thoughts, and reflections. The process notes were my notes from my session with families and were, therefore, written from my perspective. I wonder if my notes would have been more detailed if I someone else was going to analyse them. I wondered whether the fact that I both wrote and analysed the session notes may have had an impact on the validity of the research.

I also wondered whether being aware that the notes would be included in the analysis, I spent more time, wrote in more depth, using less shorthand and more clearly. When I was writing up my notes, I felt conscious of the need to be very detailed. I was also aware that I was writing notes I would later analyse and anonymise. I was aware that these would be included in the study. One of the approaches I took was to write down in detail my countertransference, free

associations, and thoughts during difficult or notable moments in the sessions. I had no idea about what would emerge in session three of the work with each family. . I tried hard to write these notes in detail and remain true to what took place and what I felt in my countertransference in the sessions. During the data analysis phase I played close attention to the powerful emotional moments that stood out.

Looking back over the research process, I realise that the final stages of analysing the data , specifically the process of gathering up emergent themes, was the most arduous and challenging part of the project. It was intellectually and emotionally challenging. It took a long time and took courage, perseverance, and a commitment to analysing the data as accurately as possible.

Most of the latter stages of data analysis took place during the Covid-19 lockdown. Much of the material relates to anxious, isolated, and vulnerable parents and their infants and the clinicians' experiences supporting them. Analysing this material requires engagement with the painful and frightening experiences of parents and babies struggling at the start of their lives and first steps as parents. Being immersed in this data at a time when anxieties were very high about health and survival added an extra level of emotional labour to this work. It took a commitment to remembering and reflecting on psychoanalytic understandings of the fears, terrors, and early anxieties of infants for me to make sense of the high levels of anxiety that I encountered in the material analysed in this study.

In 1948 Klein set out her theoretical concept of the paranoid schizoid position, a state of mind first seen in early infancy where 'paranoid anxiety' about survival of

the self predominates. I found it helpful to be reminded of this in trying to make sense of these early fears, terrors, and anxieties and how they are received and impact upon parents and the baby clinic clinicians. I found it helpful to remind myself that I was in touch with unconscious fears about survival from vulnerable babies and parents whilst I analysed the data at a time, under Covid-19 and the Lockdown, when fears about illness, death and survival were heightened.

With hindsight, if I was to redesign this study, I would recommend that during the data analysis phase there were more opportunities to reflect on the emotional impact of the work with my supervisors and the consultant psychotherapist at the practice. The data analysis process requires a certain degree of being immersed, getting lost in the depths of the data, really getting to know it and what stands out about it, before coming very gradually to emergent themes. This process requires a lot of nerve, perseverance, and negative capability.

Prior to the data collection and analysis, I considered the emotional impact of being immersed in this material over a long period of time. The following structures were put in n place to provide reflexivity. During the data collection phase of this study, the lead child psychotherapist and I would meet for 10 minutes after each session to discuss the content and impact of the session on us. This provided an opportunity to discuss the session, the problems the family were facing and the unconscious processes of the session. Once I left the placement, I continued to meet with her to discuss my study and the material I was analysing. My meetings with my research supervisors also helped me to consider the emotional impact of the research study.

I undertook the data analysis during the Lockdown period when it was not possible to meet in person. I worked mainly alone. I was immersed in data about people in distress. On reflection, I think more opportunities to reflect on the emotional nature of the material I was analysing may have made the data analysis period less emotionally demanding.

Conclusion

In this chapter I have detailed the methodology I used in this research study. I have provided a detailed overview of how the research methodology was selected, the recruitment process and outcomes, how data was collected and analysed. I also detailed how I approached and addressed the ethics of this research study. The final section included reflections on the study and looks at the validity of the study.

Chapter 4: Findings

In this chapter, I will detail the themes that emerged from my data analysis. I will set out the four main themes that emerged and the subthemes inside these themes. In sections 4.1 to 4.4, I will describe the themes in detail and provide examples from the material analysed to illustrate these themes. The four over-arching themes that emerged from my analysis are:

Being interested and receptive

Noticing signals about feelings

Encouraging agency

Providing continuity

The following table (Table Three) illustrates the four over-arching themes and their subthemes.

I shall describe in detail below each theme, providing examples from both data sets.

1	Being Interested and Receptive
1A	Encouraging understanding
1B	Taking a holistic view
2	Noticing signals about feelings
2A	Feelings
2B	Observation and vision

3		Encouraging agency
4		Providing continuity
	4A	Time and timing
	4B	Continuity of care and relationships

Table 3: themes and subthemes in findings

4.1 Being interested and receptive

The theme ‘being interested and receptive’ brings together experiences where understanding, receptivity, and a holistic view are important features in relationships. This included parent-infant relationships, relationships between parents and professionals, family relationships, and relationships between clinicians. In this section, I will provide examples from the two subthemes ‘encouraging understanding’ and ‘taking a holistic view’.

1A. Encouraging understanding

The subtheme ’encouraging understanding’ emerged from the following: First, from examples described by professionals working with parents to encourage parental capacity to understand their infant and themselves. Second, examples of parents seeking understanding from professionals about themselves and their children. Third, where parents and/ or professionals were trying to reach an understanding of the links between emotional and physical health concerns. Finally, this subtheme brought together examples of professionals providing understanding and building relationships with parents and their children which aimed to help the parent and/or child to feel understood.

The health visitor notices how parents can often feel worried about feeding and their infants' physical growth and development. Parents can become overly concerned about weight gain and want to weigh their babies more frequently than is recommended.

> *We (health visitors) are sort of managing this* ***over-measuring****,* ***over-weighing*** *of babies, which can sort of increase anxieties for the parents.*

(Interview three: p. 2, line 70)

Weight gain and the growth of the baby have important meanings. They can be healthy indicators of development, but anxious parents may become fixated on these ideas. In this extract, the health visitor emphasises the word 'over' when she describes anxious parents who insist on their baby being weighed too frequently. Fears around weight gain may be linked to unconscious fears about survival.

In the following excerpt, the health visitor describes her response to these worries. She tries to help parents understand when and how to weigh their baby. In so doing, she aims to bring understanding and to also alleviate their anxiety.

> *So, sometimes, a lot of time is spent exploring the other ways of knowing your baby is thriving well and using that as a means of reassurance rather than the scales.*

(Interview three: page 3, line 89)

The expression ‘exploring’ and the implication that time is needed to help parents find ways to know their baby is developing well stands out in this extract. I felt the descriptions conjured up the image of her working together with the parents over time to encourage their capacity to manage their anxiety about their baby’s growth and to help them find ways to understand their baby’s development.

The child psychotherapist describes in her interview how parents’ understandings of their children and themselves can develop over time:

> *We saw them several times through various crises in the family, but increasingly, this mother began to understand what was going on and various times her own mother came to stay, and I think really stirred up the feelings she had about her own childhood which had been really difficult.*

(Interview one: p. 1, line 19)

The expression ‘we saw them through various crises’ describes how the therapists saw this mother during difficult situations and how the therapeutic relationship developed over time. It also gives the impression of that the therapists helped the parent to develop a better understanding of her relationships with her family. It is implied that the therapeutic process also enabled this parent to form a better understanding of the challenges of her own childhood.

For the child psychotherapist, promoting an understanding about the link between physical health concerns and emotional difficulties is seen as an important part of her role in the GP practice.

> *We can help GPs to know the connection between the symptoms that people come with and what their underlying (emotional) problems might be. And that sometimes knowing that sort of thing, makes the actual consultation that the parent has with the GP or health visitor sufficient….it (the difficulty) ends up in not needing a referral (for psychotherapy) … the professional just knowing about it (the difficulty), and even if they do not actually say anything to the parent, that is* ***openly*** *therapeutic, the way that they listen, and reply feels very comforting to the patient.*

(Interview one: p. 9, line 296)

In this excerpt, the therapist emphasises the word 'openly' when describing the approach, she believes health visitors and GPs can take to help the patient. She is describing a capacity in the professional to help the patient feel understood, which involves an active, empathic, and therapeutic position. She also describes what this entails, knowing, listening, and replying in such a way that makes the parent comfortable. I noted how the word 'comforting' made me imagine a very anxious parent or baby who communicates a need for comfort, reassurance, and understanding.

For the child psychotherapist, the experience of being able to convey emotion and feel understood is central to both the therapeutic process and how parents are supported to take up therapeutic help. She believes that a 'continuation' of feeling understood helps the patient to transfer from the referrer to the psychotherapy service. The opportunity to convey painful feelings and the empathic, listening response provided by the health visitor or GP helps the parent to imagine a similar good experience in therapy.

The child psychotherapist describes the following process:

> *A successful referral is one where, PAUSE, they (the parent) haven't just told the doctor or the health visitor what their problems are but they have been able to convey the emotions of it and felt that that was really understood and felt that the person that they were referred to (the therapist) was a sort of continuation of that and not sort of being fended off or 'I haven't got time to deal with that so go and talk to somebody else.'*

(Interview one: p. 3, line 95)

In this vignette from the interview with the child psychotherapist, she gives an example of how trying to understand and promote understanding in the therapeutic work can be challenging:

> *My colleague and I saw this mother who seemed very distraught and who was very hard to make contact with at first. Her story about herself, her childhood, marriage, recent experiences and then the birth of her children was very fragmented. It was hard to understand it and I actually found it hard to like her.*

(Interview one: p. 2, line 70)

The description of the parent that is 'hard to make contact with' gives a sense of the therapist trying to get to know the mother. She is 'reaching' out to make contact with her, but this connection is hard to achieve. I noted that the description of this parent as being very fragmented brought an image in my mind of a parent bringing pieces to the therapist, rather than a whole picture and a whole version of herself. This extract also seems to communicate an idea that when there are difficulties in connection and understanding, it is also difficult to have warm

feelings towards someone. This is expressed as the therapist finding the parent hard to like. In my notes during the analysis, I made a link here to the experience of parents and babies where there are difficulties with bonding and where parents may say they find it hard to read and understand their babies and also find it hard to feel connected.

For the GP, encouraging understanding can involve trying to help parents take a broader view of their children's difficulties and how they understand them. An example of this is where the GP feels that the difficulty a parent brings to her has both an emotional and physical component. She tries to help parents think about the emotional underlay of the physical health concern:

> *And, parents, I think often, are very worried about the constipation or the behaviour and, trying to open up that discussion that maybe there is an emotional side to things or maybe it is more complex than they are thinking…. a broader conversation can get shut down by parents very quickly if they are not ready.*
>
> (Interview two: p. 3, line 79)

The GP is in touch with how anxious parents can feel. I noted a strong sense of fragility in her description of the dynamic between parents and GP. Perhaps what is implied here is that with high levels of anxiety, care must be taken in order to preserve the patient-doctor relationship and the patient's receptivity to receiving help. There is also a reference here to 'being ready' and a sense that getting the timing right to introduce the idea that the parent's concerns about their child might have an emotional aspect has to be carefully judged. The expression 'shut down' gave me the sense of someone cutting off contact and withdrawing from help.

There is some crossover here with the theme ‘providing continuity’ (theme 4.4), which brings together examples of relationship building and the importance of time and timing. I believe that implicit in this extract is the belief that if the GP can maintain a relationship with the parent, the parent is more likely to continue to seek help from the GP. The GP has noticed that in order to encourage a broader understanding in the parent about emotional issues, trust, time, and a relationship are necessary.

For the GP, promoting understanding of the links that can exist between emotional and physical health difficulties is something that can be challenging both for GPs and patients:

> *As doctors we are all very keen to do the medical bit so we throw laxatives at the problem, and we talk about that but sometimes we do not venture into that emotional side of things as quickly as we should so by then this horrible cycle and pattern has been set up.*

(Interview two: p. 1, line 26)

The GP suggests the ‘emotional side of things’ is difficult for both the GP and parent to think about and discuss. The use of the word ‘venturing’ stood out to me as though speaking about and thinking about emotional difficulties can feel like setting out into unknown and possibly frightening territory. The risk of looking at the emotional aspect is that the concern may return. A ‘horrible cycle’ isa term that evokes a feeling of worry and desperation, problems not being solved, and reoccurring.

Providing understanding is a theme that can also be seen in examples from the interviews where participants spoke about being actively empathic.

For instance, the GP describes ‘feeling for’, empathising with and being sympathetic to the experiences of new parents:

> *I really feel for them (parents) and so, as with the breastfeeding example, you can read four different books and websites and patient forum discussions, and everyone will tell you something different.*
>
> *And social media, <PACE BEGINS TO PICK UP> I think must be very difficult because you see photos of mums with their new-borns with all their hair and make-up done and they’re having a lovely time and their house is perfect and they’re baking beautiful cakes and actually what you are not seeing is them in the middle of the night, pulling their hair out.*

(Interview two: p. 11, line 404)

The GP genuinely cares and tries to relate to the pressures she imagines new parents feel. The pace of her speech picks up as she begins to describe two very different images and experiences of parenthood. The first is a very manicured, perfect picture of parenthood lived out publicly on social media. The second vivid image is one where the parent, in the privacy of her home, is desperately ‘tearing her hair out at night’ with her baby. The pace of her speech and the lack of pauses between her examples conveyed a sense of speed, pressure, and a building feeling of becoming overwhelmed. This change in pace accompanies the example of a worrying situation where a picture-perfect, unrealistic image of parenthood covers up the desperation and distress of a parent.

In psychotherapy sessions with parents and infants, one of the key aims is to increase understanding between the family and therapists of the difficulties faced

by the parent in herself/himself, or in the relationship with her/his child, family relationships. From the analysis of process notes of the psychotherapy sessions with parents and their infants, encouraging understanding was sometimes seen in efforts made by the therapists to encourage parents to notice and think about their thoughts and feelings. For instance, in the session with Helena and Maria:

> *The therapist says she thinks that Maria feels she has to work very hard to keep her husband calm, keep the children calm but what happens to her own anger and distress?*
>
> *Maria laughs and says that there is no space for this.*

(Session A, p.3 line 66)

In this extract, the therapist tries to help Maria have a better understanding of her relationship with her husband and her relationship with her own feelings and thoughts. In this way, the therapist tries to promote an understanding in Maria of her thoughts and feelings and what she does with strong feelings. The therapists invite her to explore her feelings. Maria's response is to laugh, but by explaining that 'there is no space', she describes something important about her relationship and her feelings about this set of family relationships. What perhaps is understood here between therapists and parent is that the parent feels sometimes she cannot be in touch with her anger and distress.

It emerged from the analysis that, at times, parents and children had the experience of feeling understood, and this was achieved by clinicians and parents taking an empathic approach. This often involved the clinicians and parents

listening carefully or being listened to, actively trying to understand, relate to and empathise with a concern.

The extract below illustrates my attempts to understand what Hayley was feeling and her attempts to help the lead child psychotherapist get to know her and her difficulties

> *Hayley listens but looks tearful and there is a hopeless feeling conveyed.*
>
> *I ask Hayley what she might be speaking to us about if she was not speaking about her daughter.*
>
> *Hayley shrugs. She asks if we want to know about her early history.*

(Session C: p. 3, line 112)

What is first noted is the feeling of hopelessness and sadness conveyed in Hayley's tearfulness that I try to understand by trying to ask about Hayley's feelings, thoughts, and experiences. An attempt is made here to promote understanding about Hayley's experience and Hayley responds by offering to speak about her past. By offering to speak about her past I think Hayley is trying to find some understanding from the therapists and herself about herself and her past.

First, I note the feeling of hopelessness and sadness conveyed in Hayley's tearfulness. I try to understand by enquiring about Hayley's feelings, thoughts, and experiences. An attempt is made to promote understanding of Hayley's experience, and Hayley responds by offering to speak about her past. By offering

to speak about her past, I think Hayley is trying to find some understanding from the therapists and herself about herself and her past.

> *The following extract comes after a moment in the session when baby Ronan was crying and appeared particularly distressed. Encouraged by the therapists to put Ronan down and lay him on the mat, Sara, his mother seemed calmer and able to speak more freely away from the baby; he is calmer too: I am taken by how much calmer things feel and how she touches him on the tummy, gently, as she speaks.*
>
> *She returns to the sofa after a little while and continues to speak about living with friends in a shared house. When she came to the UK after her mother died, when she was 18, she looked after herself. She says that she was not sure about having Ronan. She and her partner were living together at the time but had only been together for a month and then separated.*

(Session B: p. 2, line 34)

When baby Ronan is calmer and more settled, his mother begins to speak to the therapists about her current circumstances and her history, including the loss of her mother and the loss of her relationship with Ronan's father. In this way, Sara brings details of her own experiences and the challenging circumstances of her, and Ronan's lives to the session. These experiences are brought for the therapists and her to think about. In this sense, Sara seems to be seeking understanding. She is also encouraged in the therapy to understand herself and her relationships.

In the session with Maria and Helena, Maria begins to explain details of her past and experiences, exploring her identity.

> *Maria says she has been reading how babies pick up on feelings.*
>
> *The therapist says that it works two ways; babies pick up on feelings and parents pick up their babies and young children's feelings too, their worries about uncertainty.*
>
> *Maria nods and continues to look at Helena. She speaks about her mother coming to stay and how her mother needs a lot of attention too. … Helena starts to speak about growing up in her home country with her grandparents.*

(Session A: p. 3, line 84)

In this extract, the therapist responds to Maria's statement that babies pick up on feelings by speaking about how both parents and infants pick up on each other's feelings. The conversation is opened up, understanding is encouraged, and the parent then feels she can speak about aspects of her life and concerns. Her mind then seems to go to her past; another link is made in her mind, and she begins to speak about her past, being raised by her grandparents. The thinking and containment provided by the therapists allow Maria to talk about and make connections to her past. I also noted the importance of the idea that both babies and parents pick up feelings; Maria may have felt that the therapists were like parents who could notice her feelings, so she could speak more freely.

1B: Taking a holistic view

‘Taking a holistic view’ is defined here as an openness to other contributing factors that affect the emotional experience of parents and infants and professionals. It refers to taking a broad view of the circumstances and contexts in which families are being created. It brings together themes related to cultural difference, different points of view and conflict.

Conflict and difference in points of view emerged were aspects which emerged from both data sets. Conflict and difference in opinion include experiences where there are two or more conflicting points of view or perspectives. For instance where parents and clinicians describe their own experience of internal conflicts, such as the conflict parents can encounter when they have to give up their own needs and aspects of their identity in order to attend to their baby’s needs. For clinicians, these conflicts include situations where there is conflict between professional guidelines and the professional’s point of view and assessment of a situation.

The data analysis brought forth important dimensions of cultural difference in understandings of mental health, child-raising, and family structures. Examples included cultural differences between clinicians and patients and the experience of international families having children for the first time in the UK in a set of cultures and systems different from those in which they were raised.

This dimension of cultural consideration was evident from both the process note analysis and the analysis of the interviews.

The child psychotherapist describes her experience of working with parents who were raised in a different country and culture, now raising children in the urban area local to the clinic:

> *Having a baby is a passport into institutions so, through their children, they have got more routes into belonging…like coming to the doctor more frequently, going to nursery and school …. but having the baby also highlights that their parents are far away, and they do not know how systems work. And that they have not got school friends who are neighbours.*

(Interview one: p. 13, line 456)

The psychotherapist uses the word belonging to describe how having a baby can help a parent and family feel part of systems and communities. The baby's arrival reminds parents of their own childhoods. In this instance, it reminds them that they are far away from the cultures, neighbourhoods, systems, and families they were raised in. I think she describes a dual experience of loss and gain. Becoming a parent puts parents in touch with feelings and reflections about their own early experiences. It can also bring with it feelings of loneliness and isolation.

Cultural differences are also linked to misunderstandings, misconceptions, and conflicts in the material I analysed.

The child psychotherapist speaks about feeling out of place when confronted with patients where the class difference is brought to her attention:

> *We (professionals) can feel out of place by how much parents perceive it (speaking about class difference between professionals and patients). The simplest example being, working class parents thinking we as middle-class clinicians do not know what they experience. Or the young mums who assume we will disapprove of them as much as they feel other people around them have.*

(Interview one: p. 13, line 462)

This excerpt highlights how class and power dynamics can impact relationships between parents and professionals. A perceived division between 'us and them' can make it difficult for parents to feel understood. Mistrust, fear of judgment, and conflict between patients and professionals can make connecting and bringing understanding difficult. Aspects of these power dynamics include fears that the psychotherapist will not understand and will disapprove and the anxiety and discomfort the therapist feels when there is this dynamic.

The child psychotherapist describes conflicts that parents experience returning to work once they have had a baby.

> *Many more mothers are now at work and have to deal with the feelings about going back to work. They are dealing with a conflict between wanting to go and not wanting to go and whether they are able to really deal with those feelings and face them or not.*

(Interview one: p. 11, line 391)

Conflicting professional views and the conflict between the perspectives of the parent and the professional can also be seen in the interviews with the health visitor and the GP. The GP describes the conflict she experiences between general guidelines on what is best for babies and her sense of what is right for individual babies and parents.

> *I am torn between; 'I am a doctor, I am meant to be really pushing breastfeeding' but actually a happy, sane, healthy Mum who is bottle feeding their child…is better than a Mum who is struggling with breastfeeding who is going absolutely mad!*

(Interview two: p. 9, line 307)

I noted the visceral nature and strength of the words used by the GP. She says she is 'torn,' an expression that conjures up a painful conflict. There is a conflict between professional guidelines and responsibilities and her responsibilities to help the parent and baby. She vividly describes the struggling parent as 'going absolutely mad,' capturing an image of a parent who is driven mad by the challenges of trying to breastfeed. This captures a manic, desperate feeling.

Conflict was a recurrent theme in the interview with the GP. For instance, the GP speaks of complex situations when babies are born prematurely and/or there has been birth trauma and the challenges of supporting distressed parents in the medical system.

> *There are often a lot of accusations about the medical team looking after them and I feel that it is a funny mix of feeling sad <SLOW PACE> for them and feeling defensive because childbirth is risky, and childbirth is traumatic.*

(Interview two: p. 8, line 293)

The repetition of the word ‘childbirth’ emphasizes the point that childbirth is indeed risky and traumatic. I noted how the GP slowed down her pace of speech and, in so doing, seemed to consider what she felt when these situations occurred. The word ‘funny’ gave me the feeling that she was describing what it can feel like when two very different feelings or points of view collide and are in conflict. In this case, she feels sadness and defensiveness (perhaps anger). This extract demonstrates how the GP can hold conflict and conflicting perspectives in her mind simultaneously. She can empathise with the family's painful, frightening experiences while feeling protective of and believing in the work of her medical colleagues.

The GP introduces issues around cultural difference that can become complex when there are concerns about risks of abuse and domestic violence.

> *…I hope we are all aware of those cultural differences, but they are often not spoken about. I think we are all aware that some of these women are at high risk of domestic violence and female circumcision is high in this practice. Particularly, because they often come with a relative for the appointment. You can’t ask: “are you happy at home?” because their sister-in-law is sitting next to them. And that is difficult. But I think maybe although we are aware and we can list all these challenges, maybe we do not discuss it with them and ask.*

(Interview two: p. 12, line 432)

Throughout this extract, the GP refers to cultural differences being difficult to speak about, unspoken about, and challenging to raise. The GP refers to a

section of the patient population who are at risk from violence or have experienced violence. The sense of difficulty in bringing a concern up with a patient seems to be linked to a sensitivity to what can't be spoken about, fears about violence, and possibly fears about losing the relationship with the patient if difficult questions are raised, particularly when family members are present.

In the psychotherapy session notes I analysed parents also spoke about their own cultural backgrounds, family histories, their past and current family contexts, and their own early histories overseas.

> *Maria says that things have been a bit easier over the past week, she has employed a 'mother's help', a woman from back home. …. there is something familiar and warm about this, it reminds her of growing up with her grandparents and it is so good to have someone to help her out. This woman feels like a good mother to her.*

(Session A: p. 1, line 22)

The parent speaks about a 'mother's help,' which is the term used for an individual who helps take care of the children in the family home. I sensed that the 'mother's help' also symbolises a link to good experiences Maria has had of being raised by good maternal figures, like her grandparents. My sense was that being so far from her country of origin, she wanted to keep a warm, familiar connection to her first home while growing up with her grandparents. I noted that there seemed to be a wish both to be a good maternal figure for her children and to receive maternal care herself.

Other parents in the psychotherapy sessions described family relationships and their experiences of having children and making decisions about their babies far from their country of origin in this way:

> *Hayley says that she feels very different from her family back home, she is not like them. It is easier to love them at a distance.*

(Session C: p. 4, line 139)

For Hayley, there are ambivalent feelings about the family back home. She has chosen to raise her family at a distance.

> *Sara says that her family are far away, back in her country. She is here on her own with Ronan. They are living with friends.*

(Session B: p. 2, line 67)

I noted a sense of isolation and loneliness, as well as being alone with a baby and far away from family. There was also something transient about this description of living with friends. Sara's circumstances were tough. She was a single parent supporting herself and Ronan by herself. I noted a painful, homeless feeling here, where the family and feeling of connection felt far away.

Sara described her circumstances but also conveyed the complexity of feelings that she experienced as a single parent, becoming a parent, and raising her baby far from her family and culture of origin.

Individual and internal conflicts experienced by parents were also found in the psychotherapy sessions. Hayley speaks of the conflict between wanting more independence for herself and the challenges of caring for her daughter:

Hayley says she just wants to get on with her life, wants to be independent…. her daughter's difficulties with going to the toilet are about her daughter wanting to be in control.

(Session C: p. 3, line 93)

Hayley feels that her daughter's difficulties with going to the toilet are about controlling her. This extract illustrates the conflict that the parent feels between wanting to move on with her own life and the need to take care of her daughter's needs.

In the session with Sara and Ronan, Sara describes conflicting feelings about having her baby:

Sara describes returning to her home country (during her pregnancy) to see her family, telling them about the baby. She was unsure about keeping the baby. They are a religious family…. She had been worried. She says that her brother and sister-in-law had been trying for a baby for a while and there were difficulties conceiving, they have not been able to have a baby.

The therapist says that perhaps it feels like the wrong person is having the baby.

(Session B: p. 2, line 41)

4.2 Noticing signals about feelings

The theme ‘noticing signals feelings’ brings together examples of two subthemes: ‘feelings’ and ‘observation and vision’. These are themes that were prominent in both sets of data.

2A: Feelings

The material analysed from both data sets was rich with descriptions of emotions. These included descriptions of how emotions are conveyed and expressed and the experience of receiving, picking up on, and noticing these feelings. These include experiences of picking up on and noticing both positive and negative feelings. Sometimes, the descriptions were of countertransference experiences where the clinician noticed what they felt in response to the emotions communicated by a parent and child. There was a category of experiences that I referred to as ‘getting a feel’ that included examples of professionals noticing feelings to assess someone’s emotional state of mind and how emotion was communicated (or not communicated) between parents and their children. Sometimes, these examples involved the therapist, health visitor, GP, or parent describing a gut reaction, a strong instinctive, emotional response to something they noticed or witnessed in a parent or child. This section also brings together accounts of being primed to look out for emotional responses. Finally, this subtheme includes experiences of sensing when there is a lack of affect, when one would expect there to be strong positive or negative emotional responses, and where there are concerns that real feelings are being concealed.

Clinicians often described picking up on parent’s feelings and either spoke directly about or conveyed a sense of what it felt to receive the emotional weight

of parents' worry and distress. Here, the health visitor conveys her own emotional response to working with anxious parents.

> *Uhm even though it doesn't start off as an emotional concern for Mum or Dad; [nervousness and shortness of breath], if Baby isn't thriving or they (parents) do not see progress, they can develop quite a lot of anxieties around that (feeding and baby's growth) [a lot of anxious tension in voice]. So, uhm, it is almost like a double-edged sword…...*

(Interview three, page 1, line 26)

I noted a breathless, anxious quality to how the health visitor speaks here. Her pace sped up as she spoke about parents who were worried about their babies not thriving. The image of a sword felt sharp and perilous, alongside a description of vulnerable babies and worried parents. This was an important communication about how the health visitor is in touch with the vulnerability of the baby and the fears of the parents. The expression 'double edged sword' refers to something that can have favourable or unfavourable consequences. Here, the health visitor seems to be suggesting that weighing the baby can be beneficial, but parents insisting on weighing the baby too often does not help to alleviate their worries. This extract left me with a sense of how stark and intense these fears can feel for parents. I also sensed that through the anxiety in her own voice and breathlessness, the health visitor conveyed some of the intensity of feeling she notices and can feel when she supports parents who are very worried about their baby's growth and survival.

Sometimes, instinctive feelings in response to parents and children are described as important signals detected by the professionals and parents that something is not right and/ or that something worrying may be happening that may be being concealed. These are experiences that alert clinicians and parents to raise concerns and to pay closer attention. Sometimes, these experiences occur when there is an incongruity between what the patient says and the feelings they convey or evoke.

In this example from the interview with the health visitor, she describes a follow-up phone call to a parent who had previously spoken to her about worries about coerciveness and bullying in her relationship with her husband since the arrival of their baby. She feels concerned that something worrying is being concealed.

> *During our first meeting, I was concerned that her husband might be coercive. She said that he was 'just being unkind'.*
>
> *(During the phone call) She told me everything is much better and ''Everything will be fine' (anxiety in voice, faster pace of speech) …You ask yourself does this mother really feel confident that things will be fine, is there more to this situation than what she is telling you?*

(Interview three: p. 5, line 197)

There is a stark contrast between the parent telling the health visitor 'everything is fine' and the health visitor questioning herself about whether there is something worrying going on that the parent is not telling her. The use of the second person ('you ask yourself') seems to… describe a third position, an internal helpful sense of stepping back and assessing the situation and working out how to approach it.

For the health visitor, flatness or an absence of feeling can be a concerning sign of depression:

I would imagine it is very difficult to pretend that 'oh I am so happy and chatting to my baby!' when you are depressed.

(Interview three: p. 6, line 269)

In both sets of data, good feelings are described between parents and children, between families and clinicians, and between colleagues. Clinicians described the impact of being in touch with and witnessing good feelings between parents and their young children throughout the data.

The health visitor speaks about feelings of love and warmth as something that clinicians often notice and look out for.

The love that is shown to the baby is what we often notice

(Interview three: p. 7, line 291)

The health visitor described seeing a loving interaction between parents and their babies as a reassuring indication that the baby and parent are managing and developing well.

When mums are talking about their baby you can almost hear straight away (she smiles warmly) if they feel really quite proud about what their baby has achieved.

(Interview three: p. 2, line 63)

The words 'straight away' stood out for me in this expression. The health visitor describes how strong and immediate these loving, good feelings are when there

is a good developing relationship. The immediacy speaks to the strength of positive feelings that exist ordinarily in early relationships and is central to the development of the child and the relationship between parent and infant.

The health visitor says, ‘You can almost hear straight away…if they (the parent) feel really quite proud’. I think pride refers here to another important feature in a good attachment relationship where the baby feels claimed by the parent and the parent feels strongly that the baby is his or hers. The extract includes my description of how warmly the health visitor smiled at this point of the interview. It was as though her smile responded instinctively, remembering moments she had witnessed of parents conveying these feelings of love and pride. This warmth felt almost contagious. I could feel it and see her smile as I spoke to her in the interview and again when I listened back to the recording. I think this is an example of the clinician feeling the good feelings that she notices between parent and baby. The warmth in her speech and smile conveys this.

These strong, loving feelings were expressed as positive signs of bonding and development. As the health visitor explains here:

> *A lot of Mums by six weeks think their babies are absolute geniuses because the babies are smiling. So, you can often get a lot of positive feedback from Mums about their babies and their babies’ behaviour.*

(Interview three: p. 7, line 289)

The development of positive feelings, bonding, and better relationships between parents and children are important features of the child psychotherapist’s descriptions of her work with families. These positive feelings and relationships

also can develop over time through therapy. In other words, the therapy can help parents better understand and express their emotions, feel understood, and build better relationships with others and towards seeking and receiving help. She gives an example of this here:

> *The very last time I saw this parent I was saying something to her about the feelings she had actually projected into me…. I must have said something about her doing that (projecting) to her children and talking about that's why they were so stressed at times. She asked whether I did that with mine [children]…and whether I was a better mother because I was a therapist. I said, I was just an ordinary mother. And she said, 'you weren't ordinary for me', [laughs gently], which was a very nice thing.*

(Interview one: p. 2, line 48)

Speaking about sessions where she sees parents and infants together, the child psychotherapist describes noticing how babies can pick up on their parents' feelings:

> *We see the baby trying to cheer the depressed mother up, [DRAWS BREATH] or the baby that cries when painful things are being talked about or the baby who looks sort of disturbed and restless. [PAUSE]….*

(Interview one, line 175, p.6)

There are pauses between each example she gives of babies picking up on their mother's feelings. I wondered if the pauses were partly in response to the painful feeling that comes with noticing how a baby is affected by the emotion of the

parent or the painful idea that the baby 'cheers the depressed mum up.' It is as though the expected roles are reversed; the baby becomes, albeit momentarily, the carer. 'The baby who…' also seems to imply that these responses, for instance, crying, seeming disturbed, or cheering up the depressed mother, are responses she has seen often when there are emotional difficulties.

She elaborates on observations of babies picking up on feelings, where the experience of the professional being interested in and thinking about the parent's feelings can help the baby feel like another adult is taking care of their parent. Giving the baby the experience that their parent is being looked after and thought about by the therapist is an important part of the therapeutic process.

> *Uhm, I think that babies can also, even if they do not understand the words as such, can feel the distress and also can feel that the mother is being looked after by the conversation. Uhm, and can feel calmed by that as well, yeah.*

(Interview one, p. 6, line 180)

The child psychotherapist describes the feelings commonly experienced and communicated when therapeutic work starts with families newly referred to the service:

> *Yes, LONG PAUSE, I think that sometimes there is a sort of slightly desperate feeling about getting them (parents and babies) in, dealing with the referral, managing to make the phone calls at the right time….and, yes, in the first meeting, everybody is worried, and it is all upsetting.*

(Interview one: p. 12, line 425)

The child psychotherapist pauses before speaking. Listening back to this recording and analysing this section of the interview, I felt that the pause helped her gather up into words the combination of painful feelings that she notices during the early stages of therapeutic work with families. She refers to a desperate feeling', trying to get things right, and how feeling worried and upset is felt by 'everybody,' the family, and the therapists. I felt there were parallels in these feelings of desperation, worry, and upset between what anxious parents and children can feel coming to therapy and meeting the psychotherapist for the first time and the early experiences of anxiety for the parents and infant in distress. The therapist's task is to be in touch with, take in, and think about these feelings. I think 'everybody is worried, and it is all upsetting' refers to the therapist getting alongside the family and picking up on the feelings brought to the therapy to be thought about.

This extract conveys how much emotion is being communicated and felt by clinicians while setting up therapeutic work with parents. These feelings of desperation, getting things done at the 'right time', worry and upset are feelings that were commonly described by parents and professionals throughout the data. They tell us something about the intense emotions that can be experienced and communicated by parents and their young children and our sensitivity as clinicians and people to these.

The child psychotherapist emphasises the importance of paying attention to underlying feelings:

> *It is very natural for health visitors and GPs to miss out on the depressed mothers who can pull themselves together and come out looking really very well dressed and with make-up on…and partly this isn't a cover up, they look better for feeling taken care of by the GP or health visitor …. but there is just this underlying feeling that you get that something is not right.*

(Interview one: p. 6, line 199)

This was an example of a clinician referring to difficult, worrying feelings being concealed. The child psychotherapist paints a picture of a parent dressing up to conceal how she is struggling. She also points to something that all of the clinicians interviewed referred to: a sense that what appears on the surface is different from the difficulties that are being concealed underneath. These are descriptions of incongruity in effect and appearance and where the clinicians put into words a response they have when they feel 'something is not right.'

Often, the sense of something not being right is linked to experiences of incongruous affect. The GP describes an instinctive sense that 'something is not quite right' here in her description of meetings with parents where the affect that the parent conveys does not match what the parent is saying:

> *I think there's a lot of women who come in and **say** one thing, but they **appear** the opposite. And particularly if they come with their partner or their mother or mother-in-law, and they are there saying: 'everything is fine, baby is wonderful, this is great!' and you just feel that their affect is incongruous, they, they, they, just, just exude signs of depression but they say what they are meant to say.*

(Interview two: p. 4, line 139)

The GP emphasises how what is being said is the opposite of how the parent appears. I noted a trapped, constrained feeling in this description of the parent in the presence of a family member. The GP conveys the power of this encounter and the worry it can bring, partly through how she repeats her words towards the end of her sentence. The word ‘exude’ is potent; it gives a sense of it being impossible not to notice that there is something wrong.

The GP spoke of noticing how children pick up on their parents’ stress. In this extract from the interview, she describes a direct relationship between the parents’ worry about their child’s difficulty and the child becoming worried themselves.

> *You can get a feel very quickly that there is this vicious cycle that has been set up between the parent and child, the more stressed the parent and then the child gets, the worse the problem gets….*

(Interview two, page 2, line 20)

The expression ‘vicious cycle’ refers to a dynamic of cause and effect where the elements involved amplify and aggravate each other, and, as a result, the situation deteriorates. I felt that in this interview, the vicious cycle she described conveyed a dynamic with strong tension between the parent and child. They are stuck with feeling angry and worried about the difficulty and the other person in the relationship, but where change does not feel possible and the lack of change, anger, and worry feed off each other and intensify the difficulties.

A common theme from the data analysis originated from descriptions of noticing strong feelings, impressions, and instinctive reactions in response to the state of mind and emotion communicated by the child or parent, or both. I sometimes referred to these in my notes as ‘gut responses’ where the clinician felt something strongly in response to a parent and child. These responses were often described when the clinician seemed to be trying to assess what may be happening emotionally for the parent, infant, or in the parent-infant relationship.

‘Getting a feel’ is an expression that clinicians often use to speak about getting an impression of the emotional state of mind of a parent. The GP described this in the following way:

I very much feel their stress before they even sit down in the room.

(Interview two, page 9, line 334)

You just get a feel, a sense of them and that they are struggling.

(Interview two, page 9, line 359)

The first description conveys the intensity and immediacy of noticing the parent’s distress through feeling ‘their stress’ from the moment the patient arrives in the room. I noticed how vivid this image is of a parent arriving in the room and the GP immediately feeling the distress.

In the second description, the GP uses feeling and senses to try to understand what the patient is experiencing. ‘You just get a feel’ implies that there is something instinctive, an awareness of feelings, and a belief that these senses

and impressions about patients provide important information about the patient's well-being and state of mind.

The professionals and parents' responses to infants and parents in distress were frequently described in a physical, vivid, and visceral way. This can be seen in the GP's description of seeing babies admitted to hospital due to not getting sufficient nutrition:

> *We admitted one or two babies every week for NG (nasogastric) fluids because they were **starving** because the mum felt so pressured into breastfeeding…she was so determined to breastfeed that she would not give even the smallest bit of formula and these babies were **starving**….uhm, I, I, it just didn't , it did not sit well with me. It is hard to stomach seeing babies on NG tubes when we have **safe**, **clean**, drinking water in this country and we can make up formula safely.*

(Interview two: p. 10, line 251)

The GP places an emphasis on the words about babies starving in a country where there is access to safe, clean water. She is making a point about the desperation of parents who feel under such pressure to breastfeed. The emphasis on the words makes this picture of parents with malnourished babies feel shocking and that something is not right. The GP effectively communicated both the parent's desperation and her own disbelief and anger at this situation. She uses physical bodily descriptions to describe her response. The situation does not 'sit well' with her and is 'hard to stomach'. This reminded me of expressions such as 'gut reaction' which is used to describe a powerful,

sometimes physical emotional response to something. In this case, something that does not feel right to the GP and feels shocking to witness.

In some cases, for instance, where the health visitor or GP needs to look out for signs of postnatal depression, they describe being ‘alert to’ evidence of feelings or states of mind in the parent that may be harmful during health checks in the baby clinic:

> *In those checks, I am always sort of really primed to be looking out for postnatal depression <SLOW>. So, sometimes there are women who come in and they are obviously depressed, and they say they are depressed and there are the mothers where they say one thing, but the affect is the opposite.*

(Interview two: p.4, line 133)

The GP describes a state of preparedness, she ‘is primed’ to look out for a lack of affect or incongruity in affect that could be indications of postnatal depression.

In the psychotherapy sessions with parents and infants, there were examples of babies picking up on their parents’ feelings. For instance, in this extract from the session with Maria and her baby Helena:

> *Maria starts to speak about arguments between her and her husband. As she speaks, Helena who is close to her chest and looking at her face, starts to whimper. Helena starts to cry. Maria bounces her up and down as she continues to describe difficult tensions at home. Helena looks around (to the therapists) and back to her mother and lets out a loud cry.*

(Session A, p.1, line 6)

The baby starts to whimper just as her mother starts to speak about something that she finds painful and difficult. I sense that, in touch with her mother's distress, Helena becomes upset and seeks reassurance from her mother and the therapists. I noticed the upset in the baby and her mother. Here, we can see an example of both the baby and the therapist picking up on and noticing feelings. In detecting these feelings and the dynamic between the parent and baby, I am also assessing the emotional states of both parent and infant and the qualities of the emotional relationship between parent and baby.

The following extract is from the process notes of a psychotherapy session with Sara and her baby Ronan:

> *Baby Ronan makes eye contact quickly with me, he seems eager and slightly rushed to make contact... Sara is not looking at him. …. At the lift, I say hello to Ronan. I have a sense that this baby needs to be spoken to. He seems very lively, but also desperate for contact.*

(Session B, p.1, line 4)

Ronan seemed to convey distress, perhaps picking up on his mother's anxiety. He seemed to be looking for contact and wanting others to notice his feelings. I picked up on his feelings and a need he seemed to communicate about seeking and needing contact. In this extract, I detail the sense of urgency conveyed in the immediateness, rush, and eagerness I notice in Ronan's communications. This is an example of the therapist picking up on feelings, the need for communication, and gathering an impression of what the child may be feeling and what is taking

place in the parent-child relationship at this point. Namely, the child is communicating a need and wish for contact with another person while his mother is looking away and perhaps is felt to be unavailable at this moment.

In the parent-infant psychotherapy sessions, I noticed where there was a lack of feeling or where the feeling one might expect was missing. In the session with Hayley, she speaks about a painful role reversal where her daughter, first as a baby and now as a toddler, wakes her up.

> *Hayley describes how at night; she would never wake when her daughter was crying. In order to wake Hayley up now, her daughter has to get up and pull at her face.*

(Session C: p. 4, line 158)

Something is shocking and painful about this description of the force of the daughter's feelings and her mother's absence of feeling during the night. The image of a child pulling at her mother's face felt extreme and desperate. It gave me the impression that the parent was felt to be so absent in this moment that the child had to literally pull at her face to wake her up to notice her daughter's distress.

In the session with Sara and Ronan, there was a powerful set of feelings communicated by the baby. He appeared both lively and desperate for contact. I noticed I felt relieved that I was not seeing this parent and baby on my own in response to the intensity of emotion communicated by the parent and baby in this session.

Sara explains that it is very difficult with him. It is hard being a single mum, he needs her all the time and she is worried….

There are moments in this first part of our interaction when I feel very relieved that there are two of us (two colleagues) here.

(Session B: p. 1, line 13)

The expression 'he needs her all the time' seemed to chime with the desperate feeling and need for contact I noticed in this parent-infant couple. The baby felt desperate, the mother felt overpowered by his needs, and she also felt worried. My relief about not seeing them alone felt like a response to a fear of overwhelming emotion.

In the psychotherapy session with Chantal and Hayley, Chantal started to speak about her daughter's difficulties with toilet training. Her daughter had accidents and refused to use the toilet when she was with her parents. Chantal and her husband found this problematic, and Chantal felt she really did not know what to do. She described a situation when she was changing her daughter and thought she saw her eating pooh from her nappy. As she described this difficult and uncomfortable situation that she struggled to know how to resolve, I noted a lack of affect:

I start to think that there are no details of what happened, nor what she felt when she thought that her daughter was eating pooh. …I start to ask myself did she not feel shocked? Panicked? Did she not ask her daughter directly what was going on?'

(Session C: p. 2, line 68)

Analysing this extract from the notes, I noted how I was asking questions, and, in my countertransference, I felt shocked. The questions I ask in this extract point out the lack of curiosity, questions, and feelings I detected in the parent. It made me wonder about difficulties in understanding and communication between parent and child and if there were feelings of anger and resentment in the family relationships that lay beneath this difficulty. I wondered how cut off the parent was from her and her daughter's feelings.

In the psychotherapy sessions, impressions and feelings provide important information about how the parent and child may be feeling. In the analysis of my session notes, I noted how frequently I was picking up on the emotional quality of the session:

> *I notice a tense, trapped quality to how she speaks about this lack of space and imagine the family home, Mum in a dark room, little space.*

(Session A, page 2, line 58)

The image that came to my mind of this parent in a confined space feeling trapped and not being able to reach out and grow, is an example of a countertransference experience where the image that was conjured in my mind helped me to consider the emotions that were being communicated. This provided important information about emotional difficulties that this parent was struggling to express directly in words.

Here is another example from the process notes of a therapy session with Hayley and Chantal:

Hayley says Chantal wants to be a baby, when she is getting dressed, Chantal will pull at her top and grab at her breasts.

As she says this, she pulls her top down demonstrating what Chantal does. There is something that feels overly exposing about this and odd.

(Session C, p.2, line 62)

During the data analysis, I looked at this excerpt for some time, unable to be sure what feelings were being communicated and struck by how uncomfortable it felt to observe. I was curious about what the sense of feeling grabbed and exposed might tell us about how exposed this parent might feel in relation to her child's dependence on her to meet her needs. I did not yet know what was being communicated but the feelings helped to provide a more detailed picture of the difficulties.

In the psychotherapy process notes I describe what I noticed feeling in response to the child and parent as the session begins.

I notice how uncomfortable it feels to watch his legs dangle from his body as his mother does not catch them under her arms or hold him fully to her.

(Session B: p. 1, line 7)

What I think I believe I was picking up on here was the discomfort I felt watching the baby's emotional and physical discomfort and distress. Not being held in his mother's arms leaves the baby feeling like he is not held. I think

when I was writing this description down in my process notes, I was noticing how the baby did not feel physically or mentally held in mind in that moment. This was another extract that really stayed with me. I made detailed notes during the analysis of this process note to try to understand why this example was so impactful, what it might tell us about the baby's emotional experience, and what I was picking up on unconsciously his feelings and his mother's.

In this session with Chantal, I notice my feelings of being trapped:

> *Hayley says that she is not like her family. She stares intensely at me. I feel stuck to the spot and trapped by this angry look……I feel like her eyes are burrowing into me… a strong sense of discomfort.*

(Session C: p. 4, line 167)

In this instance, the emotional communication is through the parent's eyes. I felt both trapped and intruded upon by this angry look. My countertransference experience of discomfort and intrusion made me curious about why the parent felt so angry and what my discomfort might tell me about her experience.

This intense stare may capture something of what cannot yet be communicated directly about the patient's response to an interpretation I made about her feelings about being independent.

Positive feelings between parents and their babies and towards the therapists were also evident in the session notes. In this extract from the session with Helena and Maria, Maria, the lead therapist, and I enjoy these first moments of communication with baby as Helena seems to enjoy looking at everyone's faces.

Maria puts her positive feelings in to words about her baby. I think this example of the important place of positive feelings.

> *I comment on how Helena is looking very closely at my colleague and I and seems to really enjoy saying hello and finding our faces.*
>
> *Maria holds Helena close and says she is wonderful, she is so good, a bit of a saviour in these days when things are difficult with her husband and her son.*

(Session one: p. 1, line 15)

2B. Observation and vision

Throughout the analysis of sessions and interviews, recurrent examples emerged related to observation. Observation takes the form of noticing and gathering information. Each interviewee gave examples of using observations to assess a situation, emotional states of mind, or dynamics in relationships. The process notes were rich with examples of observations. This subtheme also brought together examples of parents being encouraged to use their observation skills to get to know their babies by using observation to consider what their babies may be communicating. This also includes encouraging parents to observe their emotional responses to their children and feelings.

Observation, as described in the interviews and sessions, seems to refer to what is noticed in terms of visual information and what is also noticed about affect and dynamics in relationships. In many instances, the affect that is noticed is both what the parent conveys, and the clinician notices and observes in response to

this. In the psychotherapy sessions, noticing when and how parents notice and observe their children and the feelings that they convey was a recurrent concept.

The child psychotherapist defines observation as:

> *Taking a position of 'open noticing'*

(Interview one: p. 7, line 223)

Speaking about the health visitors and GPs in the practice she describes how they use observation to notice parents and young children who may be struggling. Observation in this case employs a dual vision: noticing through visual cues and listening and being open to emotions being communicated.

For the child psychotherapist, observation makes it possible to pick up on distress.

> *The health visitors in the clinic are very good at spotting the (parents) who are not aware of their own emotions and are really covering something up. They are so open to emotions that they notice when emotions are not being properly communicated. … they can also notice when the parents are missing their babies' signals.*

(Interview one: p. 7, line 230)

In this extract, the child psychotherapist speaks about the health visitors' skills when it comes to observing and noticing feelings and when something concerning may be happening. The language used relates to seeing and observation. For example, 'noticing,' 'spotting', and observing when parents are missing their baby's signals. This extract and this final expression about signals

point to how valuable the child psychotherapist believes observation is and how babies communicate to their parents. Not yet able to communicate verbally, the baby communicates to the parent through his or her cries, movements, and signals.

The health visitor describes the prominence of observation in the baby clinic here.

> *When we are weighing babies and mums are undressing them, we are constantly looking at how they are responding to each other.*

(Interview three: p. 6, line 255)

The health visitor describes observations of parents and babies that one would see routinely in the clinic. There is something specific about parents and how they look after the babies as they undress them and expose their unclothed bodies to the weighing scale, as well as how the baby responds to this, which was spoken about in all the interviews. What is expected is that the parent will protect and take care of the baby in this vulnerable moment. She will do so by using soft, reassuring tones in her voice and gently lowering the baby into the scale; she may speak to the baby and tell her/him what is happening next. The health visitor describes ‘constantly looking’ at the interaction between parents and infants in this vulnerable moment where parental care is really needed. I noted how the description had parallels with descriptions that clinicians gave of being primed and on alert to signs of emotional disturbance and parental depression. Perhaps ‘constantly looking’ also conveys something about the health visitor being in touch with the vulnerability of this experience for the parent and baby in the baby clinic.

During baby clinic checks, the GP describes looking out for signals and signs about the relationship between the parent and the infant.

> *When they (parents) undress their child for the check, how do they interact? What happens when I make their baby cry with my cold hands, do they go and soothe the baby?*

(Interview two: p. 5, line 159)

The GP is observing the baby and parent and how they interact with one another. The vulnerability of the baby at this moment comes across in the visual image of the baby being undressed and touched by the GP's cold hands. The description in this extract, 'what happens when I make their baby cry with my cold hands,' is a vivid one where the GP is in touch with the shock that the baby might feel at contact with her cold hands and has an expectation that a parent would ordinarily empathise with the baby and respond by soothing the baby.

Similarly, the health visitor describes what she looks out for and is observing in the baby clinic with parents and their infants:

> *I think I am noticing the interaction…not just from Mum towards her baby.*

(Interview three: p. 7, line 281)

> *It is how she speaks to Baby or how she talks about what they are doing and what is going to happen next to Baby. Seeing how Baby responds to Mum. Is he or she comforted by Mum when Mum holds them or talks to them? Are they interested in Mum's face? Does the baby take pleasure from Mum's attention?*

(Interview three: p. 7, line 282)

The signs the health visitor describes sound like signs she expects to find under normal circumstances with parents and their babies. They sound like measures she uses to assess the quality of the relationship between parent and infant. She seems to describe the process that goes on in her mind as she observes this interaction and the signs she looks out for: how mother speaks to the baby, does the baby show interest in communicating with Mum, feel pleasure and comfort?

Observing interactions is a way of gathering information, as the child psychotherapist describes here:

> *But even the way that a mother comes into the room pushing the buggy you can sometimes get information from that. And, if you use those (observation skills) in the baby clinic, you will see quite a lot.*

(Interview one: p. 7, line 215)

Observation, for the child psychotherapist, is about gathering information about what you can see but also what may be happening underneath the surface:

> *We are so used now to watching television and films where directors have used very simple movements to show something that is going on more than is being talked about. We have all got observation skills these days.*

(Interview one p.7, line 213)

The skill of observing both what can be seen and what is not being communicated directly is described by the child psychotherapist in the following way:

> *One of the things that we do not have in ordinary encounters but you have in video where you can freeze frame things, where you can see a mother's hand that goes near to the baby and the baby flinches and you can think that there may have been physical abuse... sometimes you can get a feeling of it and it is worth taking note of those feelings and usually it is not imagination but something.*

(Interview one: p. 6, line 210)

> *…that is an incredible skill compared to speaking to a parent that comes in and says openly that they feel depressed.*

(Interview one: p. 7, line 233)

Accounts of observation often included describing non-verbal signs. Some of the signs of postnatal depression that the GP looks out for include:

> *… things like body language, poor eye contact, looking at the floor…*

(Interview two: p. 5, line 133)

Observation involves noticing body language, the way things are communicated by parents and their infants but also involve putting observations into words to encourage parents to notice and come to a deeper understand of their baby's communications.

In the session with Maria and Helena, I noticed gradual shifts in Helena's communications as Maria spoke about difficult tensions in the couple's relationship:

> *As she speaks, Helena who is close to her chest and looking at her face starts to whimper. Maria lifts her up and pats her back. Helena starts to cry. She bounces her up and down as she continues to describe difficult tensions at home.*

(Session A: p. 2, line 36)

This is an example of close observation in a psychotherapy session where I was noticing and perhaps also looking out for the interactions between parent and infants to get a better understanding of the relationship between the parent and her baby. I notice Helena's cries as she looks for comfort from her mother. There is something important about noticing this baby who seems to expect that her mother will comfort her and, perhaps, also that the therapists will notice her upset and take this in.

Observation in the psychotherapy sessions allows the therapist to notice and learn more about the feelings of parents and young children and the relationship between parent and child.

> *Ronan seems fractious and cries and Sara gives him his dummy …. she says he needs her **all** the time. She bounces him on her hip, and I think how big a baby he is and how petite she is.*

(Session B: p. 1, line 19)

In my analysis of this extract from the session with Sara and Ronan, the initial observation I made was of the emphasis she placed on her baby needing her '***all*** the time' combined with me noticing how large he looked as she held him. I think this extract conveys an underlying sense that she felt overwhelmed by this big baby who was also big and over-powering in her mind. In my analysis, I kept coming back to a note I made carefully analysing these notes about a huge baby and a very small woman. I sensed that his cries and needs felt too big and overwhelming to her and that she was frightened.

The theme of observation, as it emerges in the process notes, also shows the role of observation in capturing countertransference and shifts in the parent's and child's emotions.

> *My colleague suggests, and I almost let out a sigh of relief, that perhaps he might be better on the mat. He lies on this and immediately quietens, becoming interested in a toy (a small ball with mirrors inside).*

(Session B: p. 2, line 26)

My relief came when the therapist suggested that Sara move baby Ronan from her hip to the floor. The shift in emotion here is expressed by my relief and observed in how Ronan calms and is enabled to become interested in the toy when he is moved to the mat. Perhaps once away from the heightened emotional interaction between him and his mother, her feeling overwhelmed and anxious, he feels calmer and can reach for something new that he is interested in. There are concepts here, too, I noted, about what can happen when the parent and baby's distress can be contained by the therapist, and

the baby and parent can feel more able to relax and explore what is on their mind. There is also something notable here about the therapist's role in noticing the distress by observing and finding ways to help the parent and infant feel more contained. In this case, finding a resourceful solution by suggesting the baby is placed on the mat near the toys.

4.3 Encouraging agency

Encouraging agency appeared in the material in the following ways. First, examples of experiences of clinicians encouraging agency in parents. For instance, examples of helping parents to get in touch with and gain more confidence in their parental capacity. Second, it appeared in examples of parents and professionals encouraging agency in young children. For instance, examples of parents listening to and noticing the developmental steps forward that their baby or young child was making and encouraging these. Finally, this aspect includes experiences of independent and informed thinking and action. For instance, clinicians, parents, and infants where there is complexity and risk.

Encouraging agency and parental capacity is often described by the clinician as an approach that combines listening to and learning from the parent and child what the parent makes of what they are struggling with. Then, helping them find the best way to address or think about the difficulty. The child psychotherapist describes this approach as ‘listening without an agenda.’

> *…as we went on seeing her (parent) several times, she really calmed down after being listened to and, I think, being listened to without an agenda.*

(Interview one: p. 1, line 14).

She expands on this approach:

> *Listening without an agenda is actually being able to let people come and tell their stories and try and sort it out for them, yes, without telling them how to do it better.*

(Interview one: p.2, line 69)

'Listening without an agenda' involves listening attentively and encouraging the patient to work together with her to address the difficulty without telling the patient what she thinks is best. In this sense, she encourages the parent to find his or her own way.

I refer to the theme of Incongruity earlier in this chapter. There is some overlap between how incongruity is referred to in relation to risk and as it appears under section 2A of the Findings. Incongruity here, as a theme refers to risky situations where there are concerns that something dangerous is being concealed.

The child psychotherapist describes this risk in the following way:

> *Quite often one person listening to a story can be very taken in by it and not actually see what the undercurrent is…. something really nasty may be concealed.*

(Interview one: p. 7, line 265)

The language that the child psychotherapist uses is interesting. The language is used to conjure up an image of someone 'being taken in' or deceived by the story the parent is telling and being at risk of not noticing an 'undercurrent,' something

that lies beneath that ‘is really nasty.’ The child psychotherapist implies that there is a deception going on (whether conscious or unconscious is not clear) so that the clinician is encouraged not to notice that ‘something really nasty’ is being concealed.

The child psychotherapist also gives an example of an experience of trying to detect risk and parents’ resistance to this.

> *I think it was a mother who was very guarded and really didn’t want to open things up in the direction we might have gone.*

(Interview one: p. 8, line 280)

The health visitor describes the approach she takes to working together with parents that involves supporting them and encouraging them to find their own way with her support:

> *It is being able to respond to that individual person’s needs rather than having a blueprint where you say, ‘this is what is going to happen’, you have to be sort of, guided by them, in a way….*

(Interview three: p. 6, line 244)

All clinicians spoke about actively thinking about and assessing carefully and gradually when there are concerns about parental and infant mental health. The health visitor gradually appraises and assesses before deciding what to do and whether to seek support from another service.

> *You have got to sit back and let her tell the story and then from there assess whether it is something more serious that needs to be explored and supported.*

(Interview three: p. 5, line 233)

Approaches to handling risk amongst the clinicians vary, and the clinicians interviewed frequently stressed the need to maintain and build a relationship with the parent and observe carefully.

For the health visitor, her approach to supporting parents where there has not yet been a disclosure includes watching carefully for cues.

> *Sometimes you see the cues, but they are not disclosing and that is quite an interesting one to manage. Because you almost want to keep sight of that Mum and make sure that you're available to her, always go over and making a point of saying hello to her, just so there is a familiar face, a point of contact that she could perhaps….*

(Interview three: p. 10, line 507)

Another approach described seems to be to take time to assess the situation.

> *You almost need to have come from a viewpoint, even though we get many disclosures...it's a viewpoint each time as if you are not second guessing. You can't quickly jump in and say, "Ooh that's domestic violence."*

(Interview three: p. 5, line 231)

The health visitor describes a viewpoint, a place from which, at a distance, the clinician can maintain an observant position, assessing carefully over. The

expression ‘ooh, that’s domestic violence’ sounded like it had a mocking tone to it that I found hard to make sense of. The expression highlights an unhelpful approach that involves jumping in without doing the meticulous, gradual, sensitive work she feels is necessary when a situation is worrying.

The GP describes an approach that involves actively assessing getting to know, and observing a parent and child and their situation over time:

> *Sometimes we will see things and assess them for a while.*

(Interview two: p. 2, line 58)

Risks to the baby and parent can include parental mental health difficulties, domestic violence, and social and economic factors affecting the family. Personal and relationship difficulties and challenges also pose risks to the well-being of the parent and child. Clinicians referred to their emotional responses to risk and the responsibility of holding and managing risk. Risk was also referred to in the context of the relationship with parents and children.

The GP refers to the infant’s physical and psychological vulnerability to risk. The GP’s use of the words ‘incredibly vulnerable’ stresses how dependent babies are and the high risk that parental depression poses to the baby.

> *An infant is incredibly vulnerable in terms of the mother being depressed… Babies are also extremely vulnerable medically, so we are always worrying that we are missing something else.*

(Interview two: p. 8, line 274)

Risk is assessed in terms of current risk and the risk that is posed if help is not received or taken up. Here the GP is speaking about the challenges of supporting parents where there are concerns about postnatal depression.

> *…. Because you do not know how quickly that is going to change and worsen and how much they are hiding and how bad they are actually feeling at home.*

(Interview two: p. 8, line 256)

There is little punctuation in her speech in this extract. Listening to it and reading brought with it a feeling of the amount of risk the GP has to look out for and hold in mind. In this extract two of the main risk factors clinicians referred to are highlighted. Namely, the risk of change and deterioration and that the parent may be concealing how depressed and at risk they are.

> *Postnatal depression is high risk, childbirth is high risk…we carry a lot of worry. It is hard sometimes.*

(Interview two: p. 9, line 295)

Here the GP refers to the high levels of risk during childbirth .She also refers to the risk posed by depression to the parent and infant and how difficult it can be for professionals to carry this risk and worry about patients.

The theme encouraging agency emerged in two main forms in the material analysed from process notes. First, there were examples of therapists encouraging parents to share and develop their own thoughts on the challenges

they were facing. Second, there were examples of parents encouraging independence, development, and agency in their own children in the sessions.

In these extracts from the analysed psychotherapy session with Hayley and Chantal, the therapist encourages Hayley to reflect on her difficulties.

> *My colleague (therapist) asks if Hayley has had any more thoughts about the difficulties we discussed in the previous session.*

(Session C, p.1, line 14)

As the session continued, the parent started to speak about both her daughter's difficulties with going to the toilet (a developmental step that her daughter was struggling with) and her daughter's wish to grow up. I think this extract demonstrates her wish to encourage her daughter Chantal to develop and have more agency:

> *Hayley says that it is time that Chantal had a room of her own... Chantal tells her that she wants to go to 'big girl school'.*
>
> *My colleague asks how Chantal knows about schools.*
>
> *Hayley says that she sees other girls in uniform and points to them.*

(Session C, p.1, line 41)

I think Chantal also had a sense that her mother (and probably also her father, though we had not yet met him) had a place in her mind for a child who had outgrown her cot and needed her own room. Hayley encourages this development while also feeling conflicted and noticing her daughter struggles with other areas of growing up, such as going to the toilet. I also noted here that

there is a drive for growth forward. ‘She wants to go to big girl school’ combined with sadness and feeling stuck. The words I noted during the analysis were ‘development and loss.’

Examples of encouraging agency also involved parents being encouraged to make sense of their own challenges which sometimes enabled them to make links to their own early histories and difficulties.

> *The lead therapist says Hayley has studied psychology and perhaps has thoughts about what may be behind the dizziness, the feelings underneath. Did the dizziness start not long after her marriage?*
>
> *Hayley says it didn’t, it was a while between getting married and when it began. She says that her family at home were very strict.*

(Session C, p.2, line 114)

In the session with Maria and Helena there are also examples of therapists inviting parents to speak about their view of their difficulties to help them find their own understanding of what may be going on.

In this extract, the therapist asks Maria what she thinks about her husband’s anger.

> *The therapist asks if Maria thinks her husband notices how angry he gets ...*
>
> *Maria pauses and says her husband is happy… he thinks it is seasonal affective disorder and there is no need for any psychological intervention. She has noticed how his mood changes. He comes home and shouts at her and blames her for being too nice to their son (Felix)… there is nowhere for her to go in the house when*

he gets like this. Felix needs her, Helena needs her and there is no space.

(Session A: p. 1, line 52)

The parent describes what she notices about her husband's anger. The question seems to help her think about the impact on her. I sensed Maria was trying to communicate to us what it felt like to be on the receiving end of rage and feeling trapped with her and other people's anger and needs.

From the analysis of this session examples also emerged of a parental interest in encouraging agency and development in her child. In this extract, I think this is demonstrated in how Maria places her baby in the room so she can communicate with everyone. Maria knows her baby wants to make contact and encourages this.

Maria knocks on the door, and I get up to let her and Helena in. She is dressed in the same striped maternity shirt, but looks brighter, less tired. She smiles widely and says hello. Helena is in the buggy; she looks around the room to my colleague and I look at her and say 'hello'.

Maria pushes the buggy over to one side of the room, so that Helena is sat upright positioned facing my colleague and I. Helena waves her arms and Maria says something about how she thinks Helena wants to say hello. She lifts her out and holds her, back to her chest, Helena looks out and reaches forward with her arms, smiling.

(Session A: p. 1, line 2)

I noted in the emergent themes' column when analysing these notes:

Positioning the baby in relation to others: parent being aware and interested in what the baby sees and baby having relationships with others: measure of the state of mind of parent and her relationship with her baby.

In the psychotherapy sessions, there was evidence of therapists looking for changes while carefully observing and assessing the emotional state of the parent and child and their relationship.

Here is an example from the session notes with Hayley and Chantal. I note the change in her emotional state between sessions. I also note how she is 'slumped' in the chair, an image that gives me the impression she is feeling low.

At the session time, I let her into the room, and she sits down, slumps into the chair, keeps her coat on. She looks more upset than the previous session.

(Session C, p. 1, line 12)

4.4 Providing continuity

The theme 'providing continuity' encompasses descriptions and examples of experiences of continuity and time in relationships. This section had two subthemes: 'time and timing' and 'continuity of care and relationships. Descriptions of time relate to change over the passage of time, timing, and time pressures. This subtheme included the following aspects: working together, continuity, and dependence in relationships.

4A: Time and timing

In the interview with the child psychotherapist, time was spoken about in relation to how a parent can develop a therapeutic relationship through which she or he can gain insight into the family's difficulties.

As things went on, we really tried to help her with the relationship with her husband.

(Interview one: p. 1, line 25)

The expression 'as things went on' is significant. It refers to the passage of time and the progression of the therapy.

Having worked at the practice for over 40 years, the child psychotherapist could speak about many changes, including changes in the GP practice, the parent-infant psychotherapy service, the local area, the changing patient population, and understanding of mental health over time.

> *In the forty years that I have done this work, I have noticed how ordinary people are much more emotionally aware and aware of relationships and uhm, how events affect children's development, uhm. And so, they're coming for a conversation about that sort of thing.*

(Interview one: p. 3, line 106)

The child psychotherapist describes changes she has witnessed over the years she has worked in the baby clinic:

> *Now people (clinicians) are so much more overworked that they are going from one clinic to the next. And there is often bad management of not allowing enough time for opportunistic things to happen.*

…often now there are only two health visitors allowed to be in the baby clinic at any one time. Uhm, and the management rationale behind this is saying that if there were more the mothers would just want to talk to the health visitors. And, not recognising how valuable that talking is. And, that mothers quite often come to the baby clinic to have their babies weighed in order to catch the health visitors in order to talk about whatever.

(Interview one: p. 10, line 375)

There are parallels between what the child psychotherapist describes here about changes over time and the reduction both in time and the possibility for professionals to feel able to detect and pick up on difficulties the description the GP gives here of how it is now harder to detect difficulties and to get to them in a timely fashion.

That is why in the good old days continuity of care was so helpful because you really do pick up on difficulties with parents and babies a bit more when you have continuity.

(Interview two: p. 7, line 243)

She also details the impact of time pressures on continuity in the following extract.

By the time you have gone through <FASTER PACE, SHALLOW BREATH> a history taking, examination, explanation, giving a prescription, you are already well over 12 minutes as it is. And the last thing you feel like doing when you are running late is to open up a can of worms that is going to lead to another sort of 20-minute conversation.

(Interview two: p. 2, line 37)

While analysing this interview, I noted the emphasis on the expression ‘the last thing you want to do is open up a can of worms. The expression refers to a possibility that one may wish to avoid. Specifically, if you open things up and try to go into any depth, something horrible and shocking will be waiting for you. The GP’s breathing is shallow as she lists the many things she needs to get through in the appointment. I sensed that the speeding up of her speech and breathing indicated that she was in touch with this stressful feeling of the pressure of time and the fear of discovering something complex.

The start of the baby’s life, early emotional experiences and early relationships were frequently described as sensitive to time and timing.

From my notes on the session with Sara and Ronan, I noted the following:

It takes time for trust to be established: ‘it is early days’

(Session B: p. 2, line 59)

This extract from the process note captures the early nature of the relationship between parent and baby and the early therapeutic relationship. I commented similarly in the analysis of all three process notes about it taking time to build trust in these early therapeutic relationships. This expression refers to two relationships: the early relationship between parent and baby and the early stages of the therapeutic relationship.

The pressure of time was a factor that was frequently observed in the sessions with parents and their young children.

> *Hayley says she has Googled this problem (children eating faeces) and thinks she doesn't want to know and does not want this to be a problem when Chantal is a teenager. What would she do then?*

(Session C: p. 1, line 65)

Here I noted in my notes that she was conveying a fear that these issues a fear that her daughter's difficulties and dependence on her will never change.

4B: Continuity of Care and Relationships

Continuity of relationships was often described in relation to establishing long term relationships and the importance of continuity.

The health visitor describes how health visitors and GPs can have longer-term relationships with parents and families.

> *As a HV and I suppose GPs are in a similar position because they can have a life-long relationship with families, it is just keeping that door open and just always being sort of open and responsive if someone does need to talk to you or wants to see you one on one.*

(Interview three: p.5, line 218)

The words 'open' and 'responsive' seem to be some of the qualities that the health visitor feels are helpful in these long-term relationships.

For the GP, continuity is very valuable. For instance, it helps patients, it has a preventative health function (expressed in terms of saving commissioner's money), and it also makes it easier to pick up on difficulties with parents and babies:

> *Difficulties with parents and babies are easier to pick up on when you have continuity.*

(Interview two: p. 7, line 244)

> *There is so much about what we do that you can't audit it; you can't tick box it. So, the commissioners see that you're saving money and I think that is where continuity comes in, it has a huge role in helping patients.*

(Interview two: p. 11, line 393)

For the child psychotherapist, containment is provided for the family and individuals by the continuity of relationships. This continuity and containment also can be seen in how patients transfer their experiences of good relationships with clinicians at the practice to the clinic building.

> *It is also one of the pleasures of working in a GP practice, you can see people at different stages of their lives. And also, that you see them, and they go back to the referrer, they are all still part of the same setting. So, the work is there in the walls of the building. So, a consistency and containment, literally, are being provided.*

(Interview one: p. 9, line 323)

> *There was a patient that we saw in her thirties, a woman who was a patient at the practice since she was born and told us about coming to sit in the waiting room and looking out of the window there, when she was a teenager, and she was distressed and how that helped her.*

(Interview one: p. 9, line 325)

For the child psychotherapist, working with a second therapist in sessions with parents and their children allows the therapists to notice and observe more about the emotional communication from and between parent and child. She describes how two therapists working together can detect and respond to different thoughts and experiences conveyed by parents and infants.

> *Quite often one person listening to a story can be very taken in by it and not actually see what the undercurrent is, what is being concealed and the other person can actually spot **that**. So, that is one of the great benefits of it.*

(Interview one: p. 7, line 262)

The child psychotherapist also describes the support that working together allows therapists to both notice something difficult, communicate with the other therapist and help each other out.

> *And the other thing, is simply looking after each other and sometimes humour, to manage something that was really nasty.*

(Interview one: p. 7, line 265)

All clinicians described the familiarity, learning and professional support that working together with colleagues and as part of a practice team offered. The health visitor describes the support of a professional team.

> *Knowing there is a supportive hub of professionals behind you helps.*

(Interview three: p. 3, line 94)

The description of a 'supportive hub' of professionals helping the health visitor and her work with families is echoed by the child psychotherapist:

> *Now the background to this was a practice with health visitors and GPs who are very aware of the emotional needs of the patients.*

(Interview one: p. 2, line 53)

For the child psychotherapist, good referrals come from professionals and parents working well together. She believes the referral process from a GP or health visitor to a psychotherapist involves the continuation of a supportive relationship for the parent and child from one professional who has listened to and thought about the parent and child's difficulties to another. She describes how referrers have a picture in their minds of who they are referring to which helps patients feel there is someone supportive that they are being referred on to.

> *And, also, I think what helps (the referrers) is that they actually know the people that they are referring to. I think they have got a picture in their minds of some actual people who they are referring the families and not just a process and I think that is quite convincing. "I am*

referring you to these people" and not "I am referring you to a service."

(Interview one: p. 8, line 301)

The child psychotherapist describes the relationship that can sometimes develop between parents and GPs, where the parent seeks the GP out frequently for help and in distress. The dependent nature of this kind of relationship can be challenging to understand and navigate. For the child psychotherapist, GPs have often sought her help to understand and support parents when parents have become very dependent on the GP for help.

One of the criteria for actually having me at the practice was to help the doctors with patients who were referring themselves very often or bringing their children often, particularly babies. …. I remember an early referral where the patient had actually called the doctor out three times during the night, over the weekend to see a baby and each one of them had suggested seeing me. (Laughs warmly) And I did, yes.

(Interview one: p. 4, line 126)

Parents can become anxious and feel dependent on the GP for support. Here, she describes how the challenges of dependency in the parent-infant relationship can be transferred to the relationship between parent and GP. For instance, like the baby who wakes and cries in the night and leaves the parent worried, the parent calls out the GP for help through the night.

For the GP, difficult conversations with families, for instance, about risk or safeguarding, can put a strain on the relationships between doctors and patients. Conflicts and difficult conversations are more possible and successful when there is continuity of care and relationships:

> *You really need continuity for these difficult discussions to be had and we do not get that quite as much as we would like.*

(Interview two: p. 2, line 64)

Each professional referred to situations in the parent-clinician relationship where there were conflicting points of view and how important it was to acknowledge this but not put the relationship with the family at risk.

The GP describes reaching a stalemate sometimes with parents pushing for tests which she may not feel are necessary. Here, we can see that continuity in the relationship with the parent is prioritised. This make it possible for the GP to remain viewed as a source of help by the parent and a relationship to help can be maintained.

> *Sometimes you are being pressured by the parents to go down a path that you really do not feel is right. And when it is about an adult, that is bad enough, but if they want blood tests, well, fine they can have blood test and if they want some medication for this, as long as it is not dangerous, they can have it.*

(Interview two: p. 7, line 261)

The GP describes the pressure she can feel in the relationship with parents when she feels the responsibility involved in them looking to her for advice. The

responsibility of this care-giving relationship seems to be expressed in her description of patient ‘looking to me for advice’.

> *I do not want to muddy the waters by giving more conflicting information. But they are looking to me for more advice.*

(Interview two: p. 9, line 314)

The weight of this responsibility and the anxiety that can come with this is conveyed here too where the GP speaks about the high levels of anxiety that she can feel in advising parents.

> *I feel one small piece of advice from me could influence the whole trajectory of future relationships.*

(Interview two: p. 9, line 315)

Continuity of relationships and working together were themes that were found in the material from process notes.

In the process notes of the session with Sara and Ronan, there is this description of meeting them at the entrance to the baby clinic.

> *When I arrive, at the baby clinic Sara is speaking to a health visitor, it looks like the health visitor is explaining something to her, leaning in closely.*
>
> *The baby is looking around, wide eyed and smiling and reaching out with his hands, slightly snotty nosed. He looks eager and slightly rushed to make contact. Sara is not looking at him but is speaking to the woman as he reaches around with his eyes and hands and makes eye contact quickly with me, breaking quickly into a smile.*

(Session B: p. 1, line 2)

The emergent themes I found during the data analysis of this particular extract of the session highlighted how the relationships between the parent, referrer, and psychotherapy service were represented symbolically by meeting the parent and baby in the baby clinic. It is possible that Ronan's smiles directed at me came about because he recognised me and recognised me as someone like and connected to the health visitor who would listen to and help his mother.

In the sessions with parents and infants, themes around the emotional experiences of being depended upon by a young baby emerged frequently. In the session with Sara and Ronan, I noted a desperate feeling of constant needs that were demanding to be met. I picked up on a sense that baby Ronan and his dependence on his mother was felt by his mother to be too much, his feelings, needs, and wants too big and too much for his mother at times.

> *Sara explains that Ronan is very active and needs her all the time.*

(Session B: p. 1, line 19)

The pressures and demands of care-giving relationships are expressed in this session with Maria and Helena when she describes as feeling like she has three babies to take care of.

> *The therapist says that perhaps Maria notices she wants to be looked after too.*
>
> *Maria laughs and says she guesses so. She says that she feels sometimes like she has three babies at home.*

(Session A, p.1. line 72)

Conclusion

In this chapter I have illustrated how the four main themes and subthemes emerged from the data analysis by bringing examples from the analysis of the material from interviews with clinicians and process notes.

Chapter 5: Discussion

5.1 Overview of the findings

In this chapter I will bring together an overview of the study's findings and provide discussion around these. I will present those findings most significant and useful to the child psychotherapy profession. I shall discuss here each of the main findings by theme.

Being interested and receptive

Promoting and encouraging understanding is a central function of professionals' work with parents and young children. It is also a central aim of parent-infant psychotherapy, where parents are encouraged to further their understanding of their infant, themselves, and their relationship with their infant. Being interested and receptive is vital to bonding between parents and their infants.

The therapeutic space, like the consultation between GP and patient or health visitor and parent, aims to develop an understanding of the challenges the family is facing. Usually, parents bring with them to parent-infant psychotherapy a wish to find and develop their own understanding of the emotional challenges they

face with their young children and to be understood themselves. The health visitor is receptive, noticing and being interested in the parent and baby who come to see her. When interviewed in this study, she described the reassurance she gets from seeing loving interactions between parents and babies. These interactions are evidence of receptivity in the parent who feels and shows interest and care in his or her child's communications. The extracts from the psychotherapy sessions of interactions between parents and infants show how important this receptivity is. We also can see what happens when this receptivity is reduced/ altered by the parents' own experiences of low mood and depression. For instance, when Maria positions baby Helena's buggy so that Helena can communicate with both her mother and the therapists, she demonstrates an interest in Helena communicating with the adults in the room. She demonstrates an awareness of Helena's capacity and need to communicate and be part of the communication between everyone in the room. In this moment, we observe a parent attuned to her daughter's communications and her daughter's need to be seen, felt, and heard.

Understanding is a capacity. Knowing how to apply the capacity to understand is a skill for professionals. Some difficulties that are brought to the GP or health visitor are complex. They may be emotional (e.g., the baby who struggles with sleep and the parent who is very distressed about the sleep difficulty). There can be physical health concerns or both emotional and physical concerns. Where there is complexity, professionals may gather information over time from various meetings with the parent and young child to develop their own understanding of the difficulty. Professionals are also interested in getting to know the parents' and

children's own understanding of the difficulty. So, a health visitor may ask a parent why she feels her child struggles with separations at bedtime. Parents who bring their concerns about emotional difficulties with themselves and their children to professionals and parent-infant psychotherapy are usually interested in improving their understanding of themselves and the relationships in their families.

Similarly, the GP may apply a capacity to understand. For instance, the GP may meet a family member in the consulting room, where the parent brings their child with a physical health difficulty. However, the GP senses in this consultation that underlying the physical health concern are emotional factors that need to be understood. In her interview, the GP speaks about a parent who brings worries about the child's constipation to the consultation with the GP. The GP notices that there is an emotional underlay to this physical difficulty. She also notices what she describes as an emotional vicious cycle that has got going between the parent and child. The parent is very worried about the child's difficulties around going to the toilet; then the child becomes worried themselves because the parent is worried. The child may also be worried about the parent's worry about the difficulty. So, in the GP's assessment, there is a physical health difficulty, emotional difficulty, and a relationship difficulty that needs attending to.

The participants I interviewed in this study identified that an interest in and understanding of the emotional aspect of difficulties brought by patients to the health visitor or GP are not always handled with an interest or sensitivity to emotional factors. In the interview, the GP describes how, sometimes, exploring and understanding 'the emotional side of things' is given up on too quickly. It also

requires time, which the GP and health visitor may have limited amounts of. They have large caseloads and work under time and other pressures. Without time for and attention to the link between physical and emotional concerns, working towards a gradual understanding is very difficult.

The clinicians are also sensitive to timing and getting a sense of whether families are ready for psychological support. The GP used the expression ‘shut down’ to describe what can happen if she suggests an intervention, like parent-infant psychotherapy, to the family when it is ‘too soon’ for the family, and they are not yet ready to consider the emotional and psychological aspects of their concerns. This ‘shut down’ to help isn’t helpful either. She notices that the family may then withdraw from seeking help. For the clinicians, maintaining a relationship with a family is an important part of the family receiving help, and the difficulty is being monitored so it does not get worse or pose more risk to the parent and child. This sensitivity to timing and what the family can manage at a given time, in my view, demonstrates the sensitivity and capacity for understanding in the GP. The GP is very sensitive to how people can respond when the timing is not right, and they are not ready. There are parallels here, I believe, in how a sensitive caregiver attunes to a baby. The sensitive caregiver listens and observes and waits until the baby is ready. When there is too much lively, stimulating, intrusive contact from the mother, the baby turns away. There were observations of parents and infants interacting and responding in this way in the analysed process note material.

Sometimes, parents need help to understand that there is another view or perspective on the problem they are facing. For instance, the health visitor faced

with parents who are highly anxious about their baby's weight gain, must encourage parents to understand that there are other ways of knowing their baby is doing well. The health visitor encourages an understanding that there are other perspectives and ways parents can understand their baby is developing as he or she should.

Under this theme, there are examples described by the child psychotherapist, GP and health visitor that give the sense that they are in contact with, highly anxious and distressed parents, where perhaps anxiety has turned to rigidity and concrete thinking. These anxious states of mind can be very powerful and get projected into the professional (Klein, 1946). Salmonsson (2018) writing about his work supervising nurses working in a perinatal setting describes how the parent wishing to relieve herself of the anxiety she feels projects this unconsciously into the nurse. These feelings which are aimed, through unconscious communication, to get under the skin, give the nurse an experience of the helpless and hopeless feelings the parent wants to reject. I noticed how in my interview with her, the health visitor's pace of speech sped up when she was speaking about facing parents frightened about their baby's weight gain. It may be that the anxiety the health visitor conveyed in this section of the interview tells us something about how the anxiety of parents can be projected into the health visitor and other clinicians. Bion (1962b) describes containment as the process whereby the parent takes in and digests the infant's distress. This is a process where the clinician is in touch with the patient's feelings of distress, can take them in, think about them and use his or her words and actions to communicate he or she understands the distress. Here, I think the health visitor is describing a process

of being receptive to the parents' distress and being able to think about and understand it.

The GP describes carefully building a relationship with parents, the need for 'rapport,' and the need to wait until the parents are ready to receive offers or suggestions of other kinds of help. This is linked to themes of both the importance of timing and the importance of building relationships, as described in section 4.4 of the findings. For the child psychotherapist, the 'good referral' is the one where the parent has felt understood by the referring clinician. In her view, in a good referral (so, the transfer of the parent and child from the GP or health visitor to the child psychotherapist), the parent has been able to feel that the referring clinician has listened and understood her or his distress and, as a result, get a sense that the person the clinician is referring him or her on to will listen and understand his or her distress in a similar way. The GPs and health visitors speak about assessing over time and building a relationship before referring to the parent-infant psychotherapy service.

I feel that the two most salient findings in this section are: first, professionals and parents encounter but also need to be interested in and receptive to powerful emotional communications of anxiety and distress from young children and parents. Second, that understanding is a capacity that skilled professionals try to apply to their work as much as they can. It is also something that can develop over time and through the building of relationships. For instance, the development of relationships between parents and young children helps foster better understanding, as does the development of relationships between parents, young children, and clinicians.

Taking a holistic view is a collection of themes that have to do with taking a wider view and perspective. This includes noticing the place of culture and cultural difference and conflict. The families in this study were all non-British, raising children far from their own families and cultures of origin. In the psychotherapy sessions, parents described wishes to be closer to the family and wider culture they were raised in. However, two parents described their decisions to have children in the UK, far from home. One described taking a conscious decision to raise her own family at a distance from her family of origin. Sometimes, these decisions were made due to discord and family relationship difficulties.

The clinicians interviewed described how taking a broad, holistic view of the family and their difficulties was key to effectively supporting families. Themes around conflict emerged here, too: conflicts between the clinician's and parent's points of view or conflicts that parents experience in becoming parents, such as the conflict between giving up aspects of their individuality and independence to become parents. They also described conflicts they faced as parents. For example, they experience conflicting feelings and thoughts about wanting to stay with their baby and returning to work. For instance, the child psychotherapist speaks about a dilemma that modern mothers often face, which involves facing up to the feelings involved with both wanting to return to work and wanting to stay with their baby. These conflicts are emotional and powerful.

Examples of conflict between professionals and parents also emerged from the interviews. For instance, the conflict that the GP can feel when a parent wants a specific medical investigation, but the GP does not feel this is necessary. The GP described feeling frustrated when this happens. Clinicians also described the

conflict they can feel between the medical and professional guidelines they are following and what they think the parent or family may need. The GP described the emotional experience of such conflicts as ‘feeling torn’ between medical guidance and what she felt the parent might need. For instance, the GP described conflicting feelings when she felt she had to promote medical guidelines on breastfeeding to parents who are struggling with breastfeeding. Her personal view is that the baby and parent relationship would be better supported if the parent was encouraged to bottle feed her baby. The GP demonstrates how she can hold both views in her mind in these conflicts. She can both draw on, believe in, and follow medical knowledge and guidelines and also feel frustrated with the limitations of these guidelines. She can be sympathetic and empathic to the distress parents can feel when they struggle to manage difficulties with their children and feel strongly that a medical intervention is required that conflicts with the parent’s wishes.

These conflicts can be the source of frustration and anger and can threaten to challenge relationships. However, from the interviews with clinicians, there is also a sense that relationships with parents are so important that the professionals work hard to avoid conflict to promote cooperation and understanding between them and parents. Is this a reason why I did not hear as much dissent and anger as I imagined I might from professionals about these painful positions of conflict? In other words, for professionals, protecting these relationships with parents may feel like the absolute priority to keep supporting families during these vulnerable early months of a baby’s life and the new parent-infant relationship. Reflecting on this, where there are vulnerable parents and babies, relationships must be

handled with care, and perhaps this explains why the interviewed professionals spoke less about anger, as anger could threaten these relationships.

Under this section my most salient findings are first, a lot of care is taken to protect relationships even where there is conflict. Sometimes, these relationships are protected by taking distance (for instance the parents that decide to raise their babies far from their home of origin). Second, skilled professionals can hold conflict and conflicting views in mind at one time. For instance, the GP can both believe in her medical training and knowledge and feel empathy towards and sympathy for families who are in distress. She can both feel protective of her medical colleagues who did all they could during a traumatic birth and understand the pain and rage that parents who have experienced a traumatic birth can feel and the anger that they can feel towards the medical professionals.

Third, the professionals in this section describe the conflict that they felt. The GP *feels* torn; there is a strength and power of emotion that is *felt*. Feeling these emotions powerfully has a function; it allows for better understanding and more compassionate care (e.g., the GP can feel torn between her medical view and the parents' situation)

Noticing signals about feelings

Noticing signals about feelings was a theme that included the many ways in which reference to noticing feelings and the function of noticing feelings emerged from the data analysis. This included reference to being in touch with feelings, being alert to feelings, feelings forming part of a wider assessment, being alert to a lack

of feeling or incongruity, and the skilful ways that feeling is picked up on by parents and professionals.

It is clear from this section that receiving, digesting, and understanding feelings is complex and takes a lot of skill and experience. The child psychotherapist speaks about noticing that babies may look after their parents when parents show their own upset in sessions. She describes how the child psychotherapist brings her capacity to notice and observe and her knowledge of infants and their minds and parent-infant relationships to these encounters. This knowledge helps her notice the baby who looks after the parent and the parent who is in distress. The families that come to therapy are sometimes described as ‘fragmented’ or ‘saying one thing and conveying something else (a different feeling)’. Their emotional communication is not straightforward, and they need a skilled approach to understand.

This section of the findings includes many examples from the child psychotherapy session notes where the emotion being communicated is not clear. It takes thought, time, and digestion, writing notes, careful consideration, and exploration about what the patient is trying to communicate to try to understand what the patient is actually communicating.

Some of these communications are very striking. In my notes from the session with Hayley, I describe feeling ‘trapped’ by the parent staring at me. I also describe the feeling of discomfort I experienced seeing the baby (Ronan) not being held entirely by his mother. I describe sensing a feeling of exposure and disturbance as the parent re-enacts in the therapy session a situation at home where her daughter pulls at her clothes, exposes her breasts, and grabs at her.

The professional takes in a lot of emotion and projections from the distressed parents and infants. I also think that the most complex cases, where the emotional experiences are hardest to understand, come to the parent-infant psychotherapy service, where they are met with appropriate and necessary skill and experience.

Initially, I referred to ‘gut instinct’ in this section, but I realised that this was not quite right. It is more that the professional feels strong, immediate, deep, powerful feelings when they receive projections and are in the presence of people who are in a lot of emotional distress. These projections and feelings are felt ‘right in the gut .’They sometimes might even be felt physically like a ‘punch in the gut’. I think emotion is felt in this way, like a punch (like an attack) in the gut (symbolically, the gut being the place of instinct and emotion in the body) when professionals are confronted with and are on the receiving end of powerful projections. Klein (1948) writes about early defences against overwhelming anxiety, including splitting and projection. There are early, terrified states of minds that parents and infants experience where splitting and projection are used to protect the mind from being overwhelmed by anxiety.

Two other important findings are described under this theme: first, the frequency with which professionals are attuned to ‘something not feeling right’ when they meet a parent or parent and child. This includes accounts and descriptions given by the interviewees of parents they have worked with where they have noticed there is an incongruity between what the parent is saying and the emotion they convey. For instance, the GP describes a parent who says, ‘everything is fine’, but from the body language, tone of voice, and other observations, the GP feels

she knows that the parent is depressed. Professionals can feel very concerned when they notice a lack of affect and emotion towards the baby from the parent. The lack of affect can be a warning sign of depression.

From this section of the findings, one might pull up a list of the emotional signals and signs that professionals say they look out for, how they detect these signs and signals, and use them in their assessments of the state of mind of the parent and child. Professionals are 'primed' to look out for certain worrying or positive emotional signals and signs. For instance, the GP may look out for the 'red flags', the danger signs of depression. These include lack of affect, the incongruity in emotion, and noticing parents who appear to be very anxious and fixated on things like feeding at a time when it is expected that a parent would be expected to be 'fixated on their baby.' I noticed the certainty, warmth, and joy that professionals and parents conveyed when they spoke about noticing the love and warmth in parent-infant relationships. These are vital signs of good bonding and healthy developing relationships. Winnicott's Set Situation (1941), can be thought of as a collection of routine, expected observations he routinely saw in consultations with parents and infants. He felt these were indicators of the emotional stage of development of the infant. Clinicians working with parents and infants also seem to refer to observations they routinely observe and expect to observe under normal circumstances with parents and infants. I describe the Set Situation in the literature review and will return to the Set Situation in relation to the findings later in this chapter.

Feelings were often described in vivid, striking, highly expressive ways in the interviews and session notes. The powerful impact of these expressions, the

images they conjured up and the amount of focused time I spent interrogating and exploring why these expressions and images stood out; speaks to the richness of emotion that is in the data. I think it also speaks to the rich capacity in the professionals I interviewed to pay attention to and bear with powerful emotions. This finding also tells us something about the powerful nature of emotions in this early phase of life. Neurobiology, biology, and psychoanalytic understandings of early life provide explanations for the ordinary way that intense emotional experiences take place in early life.

Psychoanalytic understandings of early emotional experiences describe the powerful defences that the infant employs to manage high levels of anxiety. Melanie Klein's (1948) concept of the paranoid-schizoid position describes the anxieties, defences and states of mind that are characteristic of the early life of the infant. This is when the infant is at its most vulnerable and when the baby's ego is not yet integrated. Some of the defences employed by the infant in his or her attempts to deal with anxiety include splitting, projection, and introjection. The 'right in the gut' description I think is the feeling one experiences when receiving a full, wholesale projection.

Bion's (1962b) theory of containment and his concept of container-contained explains the process by which a baby's distress is taken in by the mother (providing containment), who, in a process of reverie and thinking, tries to understand her infant's distress. Applied to three of the kinds of relationships looked at in this study (the parent-infant relationship, the therapeutic relationship, and the relationship between clinicians and parent and baby), this unconscious process takes place in these relationships to help the parent and/ or baby to feel

that their distress has been taken in, felt, and can be understood by another. What also helps is the capacity to understand and the time to look at and digest these unconscious communications. Clinicians reported similar processes in their interviews. Examples were found in the process notes of either parents or infants feeling less anxious and more able to think and communicate once something was said by the therapist or the parent of therapist took an action to take in and understand something painful.

There is evidence from the analysis of the interview and sessions notes to suggest that to understand something, it needs to be felt. Daws (2020) describes how, in the first phase of sessions of parent-infant psychotherapy with a family, she asks the parents to describe the difficulties they face with their sleepless babies. She listens to the parent's description and the emotion about the sleeplessness 'in all its intensity'. For Daws, feeling, getting a sense of, and listening to this emotion is a crucial part of the therapeutic process. She gets to know the emotions that the parent experiences when his/her baby is not sleeping. This may be the same emotion that the baby is experiencing and picking up on from the parent during sleepless nights. Another critical function of listening and feeling in this way is that it offers the parents a sense that the therapist is 'looking after them and the emotional intensity of the situation' (Daws 2020).

Psychotherapists have supervision and personal psychoanalysis in their training and their continuing professional development. These resources help them know more about the powerful feelings they receive in their work and how to separate them from their feelings. Health visitors and GPs do not always have access to supervision and do not undertake personal psychoanalysis as part of their

training. Yet, they are on the receiving end of very powerful, incongruous, and confusing emotional experiences. GPs and health visitors could benefit from having support to think through these intense emotional encounters to prevent them from feeling overwhelmed and stressed by caring for parents and infants in distress.

Observation is a tool that gives professionals and parents important information. It helps to slow down the pace of interactions and notice what may be really going on or needed. Observation also helps the parent get to know their baby, and the professional notices if there is something worrying going on with the parent and child.

The parent is encouraged in the parent-infant psychotherapy sessions to notice how observing and wondering what the baby is communicating helps the parent and therapists learn more about what the baby needs and is feeling. There are descriptions in this section of findings from psychotherapy sessions where observing the baby has helped the professionals and sometimes the parents to know that the baby needed to be heard or needed something different. For instance, at the start of the psychotherapy session with Ronan and Sara, baby Ronan is distressed; he cries and finds it hard to soothe. The therapist offers him the mat and toys to play on. Once on the mat away from his mum, he becomes interested in the toys. The therapists' attempts to observe in that session helped them notice what Ronan and his mother might need. We were sensitive to the observation that she might need some space to talk, and he might need some play and space, too. We observed that the parent and baby might need to get

away from each other's upset. This allowed Ronan to become curious about the toys and his mother's space to sit down and talk about what was on her mind.

Bion's (1959) concept of binocular vision holds that thinking requires viewing reality from various points of view. An important finding and conclusion in this study is that this kind of binocular, double vision, and capacity to observe and notice whilst also receiving emotion, is something that skilled professionals often do and need support and encouragement to do. This double vision is for instance illustrated by the health visitor's description of how she tries to keep careful notice of parents who may be depressed.

Professionals interviewed in this study use observation to get a sense of the emotional state of mind of parent and/or infant, the development of the infant and the attachment relationship between them. Winnicott's (1941) Set Situation developed out of routine consultations with parents and infants in his work as a paediatrician. In the Set Situation, he sets out his finding that there were common ways that children communicated their state of mind, object relations, and emotional development through interactions between the child, doctor, and parent. I believe that, like Winnicott, the skilled and experienced professionals interviewed in this study use observation to look for signs of bonding, development, and factors that may threaten the bond between parent and baby and the parent and infant's development, such as signs of depression. One observation common to all professionals interviewed was how the parent positioned their baby in relation to herself and the professional. Ordinarily parents position their baby in his/her carrier close to them and in a place where the baby can see his or her mother. The GP remarks that the depressed or distressed

parent may place the baby on the other side of the room (this is unusual and indicates something may not be quite right). The GP expects the mother will reassure the baby or react empathically, shuddering or wincing herself when the GP touches the baby with her cold hands.

There are signs and behaviours that the health visitor looks out for when she is concerned a parent may be depressed. She is interested in finding out if the parent has the baby's feelings and experiences in mind. For instance, she observes how the parent takes the baby's clothes off before putting her on the weighing scale. She notices if the parent prepares the baby with her words for what is happening next. She notices and may feel concerned if the parent is silent and undressing the baby in a mechanical, automatic way. The health visitor asks, 'does she (mother) warn the baby she or he is going in the weighing scale or find ways to reassure the baby'?

When these expected reactions and behaviours are not observed in the way the parent interacts with his or her baby, the GP or health visitor may be alerted to something not being right. For instance, a parent who may be very preoccupied with something else that is worrying other than the baby, including being low in mood.

Observations of the positioning of the baby and interactions between parents and babies were noted in detail in the process notes analysed too. Sara placed Ronan on the mat when he was distressed. Maria positioned her baby in the room in a place where she was able to look at the therapists and see her mother. I paid close attention to these details which demonstrate a parental capacity to have the baby's needs and communication in mind.

Encouraging Agency

This section of the findings brought together themes, including experiences of encouraging agency, informed thinking and managing risk.

The child psychotherapist described ‘listening without an agenda’. This approach fosters agency in parents, helping them to find their own solutions to the difficulties with their child without ‘telling parents how to do it’. The health visitor described ‘sitting back’ and ‘being guided by’ the parent so the parent and child can feel listened to and helped to find solutions. In both approaches, the emphasis is placed on being present and supportive but allowing parents and children to find their own way. The approach to encouraging agency in parent-infant is underpinned by theoretical ideas of the patient using the therapist as a support to find their own ideas and mind. The interactions extracted from the psychotherapy session notes provide examples of parents encouraging agency, development, and independence in their young children. For instance, Hayley is struggling with her own difficulties and low mood and her feelings about her own development and difficult early experiences. She feels conflicted about her daughter growing up, but she can also encourage her daughter’s development and need to grow up to be a ’big girl.’

This collection of themes also highlights the high level of emotional and physical risk to vulnerable babies and parents and how professionals understand and navigate this. They are aware and sensitive to the dependency of the infant on his or her parents and the dependence of the parent on the support of professionals at times. When speaking about their role in monitoring risk to young children, the clinicians convey anxiety. As the GP describes it, ‘postnatal

depression is high risk, childbirth is high risk, and we carry a lot of worry. It is hard sometimes.' Holding the worry about vulnerable, dependent infants and parents who are vulnerable is difficult. The danger of harm is described in frightening terms; the risk can be well-concealed, difficult to detect, and easily distracted away from. Some descriptions here of managing risk involve the importance of being alert. In the health visitor's words, 'keeping an eye on that mum!'

A central finding here is the effectiveness and importance of approaches that allow the professional or parent to have another point of view or perspective and that encourages agency in the other. This view, 'sitting back' allows for space, a third position (Britton, 1989) perhaps to notice and give the other person space to find their own thoughts, ideas, knowing they still have the professional or parent's support and presence.

Providing continuity

Continuity was expressed in the following ways. It is described by the clinicians as they notice what value continuity brings to their work and relationships with parents and young children. It is also expressed in the value clinicians place on continuity of relationships between professionals caring for children and families. Continuity refers to the role of time and time pressures in relationships between parents and children and families and professionals.

The description of early relationships between parents and infants and families and professionals is accompanied by words that describe a sense of anxiety and fragility and these early relationships 'needing time' to develop. The interviewees refer to relationships taking time and trust taking time to establish. The process

note material also suggests that building a therapeutic relationship takes time. The interviewees describe how conflicts, difficulties, and difficult conversations between families and professionals can be best supported when there is continuity in the relationship between family and professional.

The analysed psychotherapy session data demonstrates how relationships are built gradually in psychotherapy. The sessions sampled from each family were the third session of treatment. In these early sessions, the therapeutic relationship is being established. There is a moment quoted in the findings from a process note of a session where a parent stared at me. This stare felt like it was full of anger after I made an interpretation about her wish for independence. I sensed she was angered by what I said but I did not yet know why she was angry. Part of the building of a therapeutic relationship involves giving time and space for patients to bring their distress and for it to be understood. It takes time for the parent to trust that the therapeutic relationship and the therapist can take in, understand, and survive the expression of anxiety, anger, distress, and aggression.

The relationships between professionals and patients, like the relationships between parents and infants need to be characterized by sensitive, careful care. There are parallels between Stern's descriptions of the attuned parent-infant couple (Stern, 1995) and the way the GP describes how she builds relationships and rapport with parents before making referrals for psychotherapy.

Collaboration and working together was a recurrent theme from both data sets. Working together came from descriptions of parents working together to make decisions and supporting one another or colleagues describing feeling backed up

by and supported by ‘the supportive hub of professionals’ they work with. The therapists and parent in the psychotherapy sessions worked together to reach understandings.

The child psychotherapist, GP, and health visitor place value on the continuity of care in relationships with families. They stress the importance of a careful handover of families from one service to the other and the importance of working together. The child psychotherapists make links with the GP and health visitor supporting the family. Through their physical presence in the baby clinic, baby clinic debriefing, and the GP coffee break, the child psychotherapists make themselves available to discuss families with clinicians. They also make themselves part of the service and keep up to date on what is happening in the service. They also make a symbolic visual link between the psychotherapy service and the baby clinic by collecting families for the first appointment from the baby clinic. They also receive referrals, discuss these with the referrer, and mention the referrer when they first contact the referred family. There is a lot of linking taking place that serves the purpose of being available and present but also in providing containment and continuity of relationships around families. What the professionals are trying to provide continuity of care and the continuity of an experience of feeling contained and understood for the patient.

I found McLoughlin’s (2010) concept of overlapping concentric circles of containment helpful in considering the systems around parents and infants in the GP practice baby clinic that provide containment. In McLoughlin’s description of working as a child psychotherapist in a pupil referral unit (PRU), McLoughlin describes a system where containment is provided by an accumulation of four

different points of contact that the young person, family, and professionals have with the containing function of the child psychotherapy service. These are individual psychotherapy, psychotherapeutic parent work, psychotherapeutic input into the professional network, and work discussion supervision for PRU staff. Each point of contact has the potential to provide containment for the young person and his or her family. The therapist brings her full, empathetic, compassionate attention to each point of contact.

There are parallels between this model, how the distress of parents and infants is contained in the GP practice, and the relationships between professionals.

The child psychotherapist describes how her presence in the clinic allows her to provide consultations to the GPs and health visitors and allows her to observe the experiences of parents and infants in the baby clinic. She also stresses the importance of the referral process of parent and child from health visitor or GP to the child psychotherapy service being one where feeling listened to and understood by the first clinician the parent speaks to can help them imagine they will find in the child psychotherapist someone who will also help her feel listened to and understood.

The points of meaningful and containing contact in the baby clinic include parent-infant psychotherapy, consultation between the child psychotherapist and the health visitor or GP, and the discussion of referrals with clinicians. Further containment is provided by the presence and availability of the child psychotherapist to clinicians in the baby clinic and practice itself, as well as joint appointments with families between families, the health visitor or GP, and the

child psychotherapist. Containment is also provided in the structures of the referral process.

Sprince (2000), in her paper Towards an Integrated Network, describes her role as a child psychotherapist providing consultation to professionals supporting traumatised children in foster care. For Sprince, consultation can further the professionals' understanding of the young person they are working with while supporting the professionals in doing their work. Consultations between the child psychotherapist and GP or health visitor may help them to understand a family's difficulties and, as a result, feel more contained and equipped to support the family.

This is achieved by the psychotherapist noticing, listening to, and providing interpretations of the projections the professional receives from the young person or family when discussed in consultation or supervision. Salomonsson (2018), describing his work supervising nurses in a perinatal clinic, observes how the containing structure of regular supervision allows nurses to bring their emotional responses to the powerful projections they receive from parents. The availability of the child psychotherapist in the baby clinic to provide consultation allows for a similar process to occur.

Sprince (2000) and Ansaldo (2021) draw our attention to the child psychotherapist's training and expertise in noticing unconscious processes. For Sprince, this enables the psychotherapist to understand the powerful feelings a young person may be projecting into the network of professionals around him or her. It also allows the psychotherapist to provide valuable insight into organisational dynamics. Armstrong's (2005) concept of the Organisation in Mind

identifies how emotional experience moves through the members of an organisation; it is not an individual experience alone. In the baby clinic, the emotional experience is felt and held at different levels by parents, infants, and clinicians at different times. The strongest evidence of this can be found in the visceral expressions of emotion in the interviews, session notes, and countertransference experiences I recorded in the notes.

Timing and time pressures were referred to across the data. There are examples from both data sets of how receiving and understanding a family's distress can take time. There is a real threat to these carefully built, necessary relationships posed by time limitations and pressures. Judging timing is also vital in care-giving relationships. For instance, the GP has only 12 minutes per appointment to speak to the patient. The time pressure can prevent her from trying to find out more about the emotional difficulties of a parent. She says she can fear opening up a can of worms in appointments with some patients. The fear is that something complicated may come to light, and there may not be enough time to help the patient. She also feels that 12 minutes may not be enough time for the parent to feel able to speak about what they are actually worried about. Time pressure can stir up anxiety in caring relationships between professionals and families.

The child psychotherapist notes how the demands and time pressures of modern life have increased and can interfere with natural timings. For instance, she has noticed that fathers are pressured to be at work, preventing them from being involved in the parent-infant psychotherapy sessions.

Continuity also allows clinicians time to think and support families. Continuity and consistency are approaches that underpin a lot of approaches offered to parents

to help children with emotional regulation. There are parallels here between the needs of young children and parents in relationships with caregivers and healthcare professionals.

Chapter 6: Conclusion

Introduction

In this chapter I will consider the strengths and limitations of this study and what I have learnt by undertaking it. I will make recommendations for future research and practice and provide a summary and final thoughts.

6.1 Summary

In this study I used a qualitative research methodology to explore the contribution that a child and parent-infant psychotherapy service in a GP practice makes to supporting parents and infants. I undertook a literature review setting out a range of literature on consultation and clinical work by psychotherapists in primary care and in parent-infant psychotherapy, policy and training for GPs and health visitors in the areas of perinatal and infant mental health. I analysed the material gathered from interviews and process notes using Interpretative Phenomenological Analysis (IPA) and presented my findings in this thesis. Four main themes emerged from my data analysis. The four main themes are ‘being interested and receptive’, ‘noticing signals about feelings’, ‘encouraging agency’ and ‘providing continuity’ I discussed these findings in the discussion and brought together what I felt were the strengths of the study, its limitations and recommendations in the conclusion.

6.2 Strengths of the study

One of the main strengths of this study was the detailed responses in the interviews. The interviewees were willing to speak freely. They spoke about their experience of working with parents and young children where there are emotional difficulties. They described the approaches they take, the challenges they face, and the interest they have in their work. The service is a long-standing one, and both GP and health visitor were familiar with making referrals to the service and having consultations with the therapists. This made it possible for them to speak from experience. The openness of the interviewees and the depth of the interviews provided a wealth of material to analyse.

As far as I am aware, this is the only study of its kind to investigate the contribution of psychoanalytic child psychotherapy to work with parents and infants and the clinicians who support them in a GP practice.

A further strength of the study was that the data was triangulated. I used both interviews and process notes; while this had its complications, it also provided some triangulation.

6.3 Limitations

There are some limitations to this study. First, there were biases in the project. One of the biases of this study was that I only interviewed highly skilled and experienced professionals who notice, are concerned about, and want to talk

about the emotional aspects of their work with patients. It may have been interesting to hear the view of a professional newer to the practice with less experience in dealing with emotional distress in parents and young children.

Second, this research project arose from my experience of carrying out therapeutic work, consultation, observation, and witnessing the work of clinicians in the baby clinic of a GP practice. I had worked at the practice and its clinicians and saw how parents and infants were supported there. I had been part of that endeavour. Therefore, I saw that child psychotherapy and psychoanalytic understandings of the early emotional experiences of parents and infants had much to contribute to parents and infants in distress and supporting the clinicians who carry out this work. My working relationship with the consultant psychotherapist also influenced my views.

Another limitation of the study became apparent when I came to the end of the writing-up stage of my project, when I looked at my findings with my supervisors. My supervisors and I noted how little dissent and conflict appeared in the data collected from the interviews. For instance, professionals complained little about the conflicts they experience in their work and the challenge of holding and working with the emotional needs of very vulnerable families and individuals. They also made little reference to challenging relationships with other professionals and patients.

In considering this, I realised that there is conflict expressed in the interviews, but it is subtle. The GP can speak about feeling frustrated and conflicted and give examples. However, there is little direct complaint or dissent. For instance, she describes feeling conflicted when she is faced with a situation where a patient

feels he or she knows best, and the GP and colleagues have a medically informed approach that is different from the patient's point of view. I think that the lack of direct expression of conflict or dissent speaks to how professionals and parents handle the fragility of early relationships and the vulnerability of infants and parents with mental health needs. Maintaining relationships with distressed families feels vital for professionals to continue trying to help them receive help. Avoiding conflict is sometimes the route that may be taken to maintain these relationships. Looking back over the interviews, I think I could have done more to explore these feelings of dissent and conflict by asking more questions about the challenges of the work and their experiences of managing difficult situations with patients.

I also wondered whether my own connection to the practice limited the study. The psychotherapy notes that were analysed in this study were mine, and I interviewed the professionals. I wonder if my identification with the parent-infant psychotherapy service, psychotherapy, and an interest in the emotional aspects of their work, may have made it difficult for clinicians to disclose negative feelings about the work. This is perhaps another reason I heard less about their negative experiences. The interviews, while conducted in a natural setting, were conducted in their places of work. This may have left them feeling restricted in how freely they could speak about the challenges of the work.

Another limitation was that I undertook nine interviews and collected a great amount of material to analyse. I did not analyse all the material and the number of interviews analysed was limited to three. The size and scope of this study meant that time was limited for analysing interviews. The interviews and process

notes were analysed in depth. IPA requires this level of depth. More time and resources would be required for a study involving more interviews.

During this project's write-up phase, my supervisors asked why I did not interview the parents. I used process notes to represent both the parents' and infants' experiences as I observed and heard them, but I did not interview the parents. This is something I had not considered before the question was asked. Using interviews with parents about their experiences would have been a different research project but may have offered the possibility of gaining more insight into their lived experiences.

Another challenge of the study occurred when I tried to combine and marry up the two data sets. The interview transcripts and psychotherapy session notes were different data sets. I found the psychotherapy sessions harder to analyse even though the themes emerged more

6.4 Recommendations for future research

In this study, I interviewed experienced clinicians who were working in a practice where child psychotherapy and ideas about the emotional relationship between patients, their difficulties, and their GP or health visitor had been taken on board to a significant degree. Psychoanalytic psychotherapists have worked and supported clinicians at the practice for over forty years through services for children and adults. Balint groups and consultation to the staff were also provided. I interviewed a health visitor and GP who described using observation, their instincts, and being sensitive to the emotional interactions with distressed

families. In the interviews, they spoke to me, a child psychotherapist, who they knew was interested in emotion.

A recommendation for a future research study, could involve interviewing health visitors and GPs working in a practice without a history and experience of having a psychotherapist present. This study would be a comparative one, looking at the experiences of primary care clinicians working at a GP practice with a child psychotherapist and clinicians working at another GP practice without.

Future larger studies could include interviews with more GPs and health visitors working in the practice. The advantage of a larger cohort is a broader range of experience and points of view. A future study might also include interviews with parents about their experiences of being supported by the baby clinic and parent-infant psychotherapy service. In terms of bias and ethics, the interviewer would need to be someone other than the therapist who sees the family for therapy, in my view. There may be issues of triangulation here, though, as there would only be one data source: interviews.

Another future study consideration might be using the Free Association Narrative Interview (FANI) method. Described by Holloway and Jefferson (2008), this qualitative method emphasizes the use of free association. Using the methodology, the researcher interviews participants twice. The rationale behind this is that during the first interview, unconscious defences may be high, making it difficult for interviewees to discuss topics in a meaningful way. A second interview can encourage trust, and, in turn, help reduce defences, making it possible to look at the topics already discussed in more depth.

6.5 Recommendations from study

I would like to highlight three recommendations from the study.

First, child psychotherapy services that are accessible to families and primary care clinicians can contribute to supporting the mental health needs of parents and young children. This study suggests that professionals who are supported to listen to and receive their patients' distress can also help patients build relationships with other sources of help.

Second, proposals for child psychotherapy and other psychotherapeutic services in primary care may need to focus on the value to patients and primary care clinicians and the financial value of early intervention.

Future proposals for child psychotherapy and adult psychotherapy services in primary care may benefit from demonstrating the savings these early interventions could bring about.

Finally, child psychotherapists can contribute valuable knowledge, skills, and experience to the training of primary care clinicians. Primary care clinicians and child psychotherapists working together could provide vital early interventions to parents and infants that are accessible and flexible and can support early relationships, physical and mental health, and well-being.

6.6 Final thoughts

This study suggests that having a child psychotherapist in a GP practice could help clinicians to think about the emotional states of parents and infants. It suggests that where there is a well-established, consistent child psychotherapy

service providing therapy and consultation to staff, staff may feel more able and encouraged to be in touch with and speak about what they notice about early emotional difficulties. The GP practice in this study valued and made good use of the psychotherapy service and the psychotherapist's expertise in thinking, observing, and supporting the emotional needs of parents and young children.

I would have liked to have found a way to recommend a child psychotherapy service in all GP practices. This study is a study of a single setting so it cannot demonstrate this. However, I hope this study will give power to the argument for this kind of service and collaboration between primary care clinicians and child psychotherapists. This study helped me appreciate my own place in supporting families and strengthened my belief in teamwork. It has bolstered my resolve and commitment to working with and learning from other professionals, young children, and their families.

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Appendices

Appendix 1: Information Sheet for Parents

Patient information sheet
Version number two
7 August 2017
Brief study title Child psychotherapy in a GP practice with parents and infants
IRAS ID xxxxxx

Research into child psychotherapy in a GP practice

Patient information sheet

Dear Parent,

You have asked to be referred to the parent-infant psychotherapy service.

I am carrying out research into the emotional support that the parent-infant psychotherapy service offers. I would like to invite you and your child to take part in the research.

Before you decide whether to take part it is important that I provide you with enough details of why the research is taking place and what the research would involve.

Please take time to read the following information. You may wish to discuss it with your partner and/or relatives, and/or your referring GP or health visitor before making your decision. You can also contact me through the details provided below if you would like further information.

What is parent-infant psychotherapy?

Families are referred to the parent-infant psychotherapy service by their health visitor, nurse or GP when parents feel that there are emotional difficulties they would like to think about. For example, you may be finding some of the aspects of your baby or young child's life and your life together difficult, e.g. weaning, feeding, bonding, sleep difficulties or separations, difficult pregnancies or birth.

You may want to use the sessions to think about your own thoughts and feelings or about your relationship with your baby and wider family relationships. There may be experiences of your own childhood that you feel more in touch with since becoming a parent. Thinking about these can help improve your understanding of your own child's experiences of being parented and your bond with your child.

The child psychotherapists you see have specialist training and experience in understanding the establishment of a baby's early relationships and how this contributes to the baby's development. Psychotherapy at this early stage of your child's life and your life as a parent can also reduce the likelihood of problems becoming more complex.

What to expect

Psychotherapy sessions are lead by what it is that you would like to think and talk about. Sessions will offer you the chance to think with two child psychotherapists about the issues that

Appendix 2: Semi-structured Interview Questions

Semi Structured interview questions:

What would you say are the common difficulties, of an emotional nature, which parents and their babies come to the baby clinic with?

What have you noticed about the states of mind of parents and infants?

What have you noticed seems to help when you meet a parent/ parent and infant in distress?

What would prompt you to make a referral to the parent infant psychotherapy service?

What would help you as a clinician to help support parents and infants?

Can you tell me about an example of a parent and infant or parent or family who came to see you where there were difficulties of an emotional nature?

What is most difficult when trying to support parents and infants in distress?

What are the biggest challenges for you as a clinician in supporting parents and infants?

What do you think are the biggest challenges to parents and their infants?

Appendix 3: Example of Stage 1 IPA analysis

Key

Column one: Emergent themes

Column two: Transcript. Where excerpts are highlighted in green, these are statements that stood out to me, describe poignantly something about the interviewee's experience and are areas I may return to when exploring themes further.

Column three:

Initial analysis following IPA guidelines

Normal text font used to denote where I am stating what the interviewee is speaking about.

Italics are used for descriptive comments

Underscored text – used to denote concepts

Emergent Themes	Original Transcript	Exploratory Comments
	FT: I am going to start by asking you, if you could think of an example of a parent and infant who came to see you, where there were difficulties of an emotional nature. If you have got that in your mind, what might be the things that you picked up or noticed, what might you be able to tell us about that? GP: DRAWS BREATH, LONG PAUSE GP: So, a specific example to be thinking of? FT: Yes, or you might have a number of examples that you draw on that present with common difficulties of parents and infants in distress. GP: So, I think a common difficulty is. Well, this is an extreme example but I am thinking of parent and young child and the child has constipation….Tell me if this is not the kind of example you need… A common example is where a child and parent come in to see me with a physical problem, for example constipation but very quickly you can see that the biggest	

Parents who come to the GP with their children with physical issues that have an emotional underlay Constipation in young children: physical and emotional distress Parents bring the child: a child and parent present with the problem Emotional underlay to physical health difficulties Something medically wrong combined with high levels of anxiety Child picks up on parents' distress about child's physical difficulty A vicious cycle is set up (physical and emotional issues): urgency, panic, stress, something entrenched GP relies on what she sees, notices, picks up on Use of language to describe a picture of how GP relies on what she sees and notices 'You can get a feel very quickly' : feelings and observations are important	problem is the emotions around it. So, the parents are worried that there is something medically wrong but they are also very stressed. You can see that the child is sort of picking up on this and you can get a feel very quickly that there is this vicious cycle that has been set up. And there is one, extreme example of a Mum and her young daughter that I have seen quite a lot where that has been the predominant thing and the child has ended up with a lot of psychology, psychology sessions to help unpick that relationship. Is that the sort of thing that you mean? FT: Yes! GP: Uhm. And I think that as doctors we are all very keen to do the medical bit so we throw laxatives at the problem and we talk about that but sometimes we don't venture into that emotional side of things as quickly as we should so by then this horrible cycle and pattern has been set up and it is hard to undo, I think, in my experience. <PAUSE>	Working with patients (parents and small children) who present with physical problems with an emotional underlay GP is presented with a physical difficulty by the patient, but she feels that the major concern is emotional, not physical. <u>S takes both aspects of the patients' presentation into account; what they say is the problem (physical) and what she also notices (emotion including stress and how the child responds)</u> *S uses active verbs and action to describe like 'you can see' and 'you can get a feel' and 'picking up' process and what she is doing, actively, when she is assessing the parent and child and situation.* *S uses 'you' perhaps to draw a picture for me? To help me see what she does or make a link between me and her, something collaborative about this?* *Use of words that denote sensitivity and emotion: 'feeling' and 'unpicking' and 'relationship'*

Observing a vicious cycle in a relationship between parent and child around a physical issue Physical difficulties like constipation have emotional meaning Stress about physical difficulties may lie in difficulties in parent-child relationship Doctors can take an initial medical view excluding emotional factors Sometimes we don't venture into the emotional side of things as quickly as we should Throwing laxatives at the problem Something frightening about looking at emotions 12-minute GP consultation: time limits GP consultation involves history taking, examination, explanation, prescription Not enough time for emotional assessment The last thing you feel like doing is opening up a can of worms when you are running late	FT: So, they might be returning to you with the same problem? So you are, of course doing you are expected to do, which is to provide a medical solution. What do you feel? might stop you from taking up the emotional part? GP: So I think, several things, if I am honest, the biggest reason often is time. That, by the time you have gone through <SHALLOW BREATH> a history taking, examination, explanation, giving a prescription, you are already well over 12 minutes as it is. And the last thing you feel like doing when you are running late is to open up a can of worms that is going to lead to another sort of 20 minute conversation. I think, also, feeling under-skilled and underprepared to deal with the anger.	*'Vicious cycle has been set up' – very descriptive, urgent, stuck and frightening quality to this.* <u>Concept: underneath the stress about physical difficulties may also lie difficulties in the parent –child relationship</u> Doctors can take an initial medical view excluding emotional factors '*we are all very keen to do the medical bit so we throw laxatives at the problem' – 'throw' perhaps indicates an idea of providing a quick, intense response, urgent? 'Horrible cycle…hard to undo' denotes the entrenched, frightening, stressful nature of a powerful cycle and difficult dynamic in relationship between parent and child?* *'We don't venture into that emotional side of things as quickly as we should'* <u>looking at emotions can be a new and frightening territory</u> <u>is there something taboo or frightening about engaging in the emotional side of physical complaints?</u> What stops her from speaking about the emotional side of the physical difficulty with patients

Conversations about emotional difficulties take time Feeling under-skilled and unprepared to discuss emotional difficulties with patients Time pressure Fear of 'opening can of worms' (disturbance and fear) Speaking to patients about how they are Feeling Not asking about emotions in the first place Avoiding feeling helpless if patients speak about their emotional difficulties Helplessness and not knowing are Frightening The doctor seen as all-knowing Recurrent attendances by patients Patient keeps coming back with the same Problem Trying to build a relationship with patient 'Things fizzle out' – relationships are fragile		*'if I am honest'* – wish to be sincere? *Shallow breaths denote speeding up of pace and anxious feeling perhaps related to fear of there not being enough time that she* *is describing*. <u>Fear that there is not enough time to attend to patients' concerns adequately</u> *'the last thing you want to do…running late…opening up can of worms' – starting a conversation about emotions may lead to something ominous, unpleasant and unmanageable for the GP (and patient?)* Speaking to patients about how they are Feeling *'I feel underprepared' uses language to describe how she feels about prospect of receiving patient's emotions and her state of mind facing complex situations and time pressures* <u>Helplessness is frightening and needs to be avoided sometimes</u> Working with patients who return with physical difficulties which have an emotional underlay

		Emphasis on the word 'know' – 'know' communicates here both certainty and a depth of knowledge where knowledge about a patient involves the GP noticing what patients do and how they interact with the GP and appointments -perhaps a sense that 'knowing' implies a duty of care, duty to notice, duty to keep an eye on patient

Appendix 4: Health Research Association Approval letter

NHS
Health Research Authority

Ms Felicity Tyson
Child and Adolescent Psychotherapist in Doctoral training

16 August 2017
Email: hra.approval@nhs.net

Dear Ms Tyson

Letter of HRA Approval

Study title: The contribution of child psychotherapy to work supporting the emotional difficulties of parents and infants in the baby clinic of a GP practice

IRAS project ID: XXXXXXXX
REC reference: XXXXXXX
Sponsor University of East London

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

Participation of NHS Organisations in England

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

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

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

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