What can be learned from referrers' experiences of using a parent-infant mental health pilot project for children under five?

David Churchill

A thesis submitted for the degree of Professional Doctorate in Psychoanalytic Child and Adolescent Psychotherapy

Tavistock and Portman NHS Foundation Trust

University of Essex

September 2023

Abstract

This research project set out to explore what could be learned from the experiences of referrers who used a parent-infant mental health project for children under-five. My intention was to learn from the participants' experiences to support the pilot project to evolve and improve the service for children, their parents and the infant mental health professionals who will refer in the future.

For this qualitative study I gathered data from four participants who had referred to the pilot project and conducted semi-structured interviews online, due to the Covid19 restrictions at the time. I used an Interpretative Phenomenological Analysis (IPA) methodology as I felt was best suited to analyse how people make sense of their lived experiences. IPA is engaged in a double hermeneutic and the researcher has a dual role, which involves continual reflection to make sense of the participants' thoughts who are themselves attempting to make sense of their own situations. After analysing the data, I organised my findings into three superordinate themes: the reasons for referring to the service; the experience of the service and the outcomes from referring to the service.

This research found that the referrers viewed the pilot project as a valuable source of specialist information and that the process of consultation was cathartic and containing. However, there was a disparity in the pilot project's understanding of itself as a primarily consultation-based service and the participants' belief that direct and potentially long-term work would be offered to their patients after referral. This led to frustration for the referrers and their patients. Recommendations are made for practice and for future research.

Contents

List of Tables

Acknowledgments

I would like to thank my research supervisors, Brinley Yare, Elena Della Rosa and Jenifer Wakelyn for their time, experience, and advice in completing my research project. I would also like to thank Ricky Emanuel, Gianna Williams and the late Louise Emanuel, whose work and practice I find thought-provoking and inspirational.

I would like to thank my father and grandfather, who I can see more clearly now.

Lastly, I want to thank Sophie who has been on this wonderful and challenging journey with me from the beginning.

Chapter 1: Introduction

1. Aims

The title of my project is *'What can be learned from referrers' experiences of using a parent-infant mental health pilot project for children under five?'* The aim of my research is to explore the experiences of professionals who referred to the pilot project - to investigate their experiences of referring, presenting their patient(s) to the Consultation Group, their views on therapeutic and educational services provided and if using the service supported their personal mental health.

2. My research journey

I find early intervention work with under-fives', the formation of young children's relationships with parents and how these experiences affect their understanding of the world fascinating and fulfilling. In my experience in numerous children`s and adult`s settings, early intervention offers the best chance of positive outcomes for the child, for the family and for society.

My interest in working with children under five stems from my own upbringing and the influence my mother, father and extended maternal family have had on my life. I was extremely lucky to have deep, strong and caring relationships with my father and maternal grandfather, very different men who taught me about the beauty of life, love, and the importance of learning to understand yourself.

My experience working in a Montessori Nursery School as a part-time teacher, while studying for a Psychology degree, helped me understand that my calling is to work with young children. It was also the start of the journey that has led to my doctoral research into the experiences of referrers using an under-fives pilot project. While working in the nursery, I began to remember long forgotten moments from my own childhood. I found working with young children enabled me to reexperience the trials and tribulations of early life - being able to understand these moments from an adult perspective was a profound and illuminating experience.

In the nursery, I noticed that the troubled boys gravitated towards me and needed something from me, the only male teacher, which I found intriguing. My colleagues and I recognised the benefit of having a male teacher and a more gender diverse workforce as the children needed different support from different teachers at different times. The boys who wanted my support struggled with sedentary learning and needed to play boisterously to concentrate and to cope with their internal worlds. They were often chastised for not listening to teachers and disrupting group activities. I intrinsically understood their need for movement and their difficulty in processing verbal communication when trying to concentrate. Consequently, I used far less spoken language when working with them. I learnt that when these boys were dysregulated, they experienced verbal communication at intrusive and overwhelming - being 'spoken at', rather than 'spoken to'. Just spending time with these boys in the nursery, simply listening to and taking in their verbal and non-verbal communications, proved extremely effective. They appeared to feel understood, and this helped them to calm more quickly and to re-engage with the other children and the teachers more readily. I soon realised that my interest in working with young children was not educational, but in working at depth with children who were struggling and experiencing psychological difficulties.

Heather Morris (2020) highlights the developmental and emotional benefits of being listened to and being found interesting by a caring adult. She emphasises the difference between phatic listening, listening to reply or communicate, and what she describes as true listening, to understand and find deeper meaning. Morris (2020) writes of being curious about the message behind both the words that are spoken and non-verbal communications. Her thoughts resonate with me as I have vivid memories of both listening to my father and grandfather, learning interesting things, and also being listened to by them and being experienced as interesting. As an adult, I can see how this has enriched my life immeasurably.

I believe a fundamental strength of child psychotherapy is the opportunity for a young person to spend time with an adult who can take in chaotic thoughts, or beta elements (Bion,

1967/2018) without being overwhelmed, disgusted or judgemental. I, like Heather Morris, felt contained, understood and calmed by spending time in the presence of adults who gave me time and valued me. This experience underpins my decision to become a child psychotherapist. I agree with Caryn Onions (2009) who believes clinicians are drawn to parent-infant psychotherapy as it offers a unique sense of hope that we as child psychotherapists can engender meaningful long-term change. During my research, I came to understand how working with young children reminded me of the magic moments and tragedies of my own youth, perhaps allowing me to process them more fulsomely. I believe that working as a child psychotherapist offers a unique opportunity to learn from the children we work with and to continue to grow as people and clinicians, thus making us better therapists in this circular evolution.

The place of males in under-fives settings and my position as a male researcher in a predominantly female workforce became a significant theme in the research and is considered in more depth in the Discussion and Conclusion chapters.

As a first-year trainee, I was tasked to carry out an audit of the effectiveness of psychotherapy in our trust that looked at the caseloads of the psychotherapists in our team. Through observation and consultation with the managers of the Child and Adolescent Mental Health Services (CAMHS) and CAMHS-Learning Disability teams, I learned that while the service accepts referrals for children and young people aged from 0–18 years, in practice children under five are rarely seen. The vast majority of children under five were seen by child psychotherapists and most of these young patients were seen by trainees as one of their supervised intensive training cases.

I was concerned about the long-term effects to the child and family of not receiving early intervention and how this might adversely affect their long-term life prospects. Moreover, it appeared this way of working had become systemic and entrenched, creating what Reed and Parish (2021) call a ‘baby blind-spot’, where very young children do not receive the

crucial intervention they need at the appropriate time. This seemed unlikely to change if under-fives were not being referred to CAMHS.

The role of CAMHS in our trust has changed significantly over time. Much of the less risky work, which tends to be more preventative in nature, has been outsourced to charities and external services commissioned in an attempt to reduce CAMHS waiting lists. CAMHS now has a larger concentration of patients at higher risk, which translates into CAMHS workers with often overwhelming caseloads filled with risker patients. The result is that preventative work is now far less common. I began to wonder about the under-fives and under-fives workers supporting these young patients and their families, who might experience burnout and secondary trauma due to their challenging roles.

I was initially interested in setting up an under-fives clinic in my CAMHS setting and I researched how similar projects were set up. I came to understand the significant barriers these projects faced, both conscious and unconscious. On reflection, I felt an attempt to set up an under-fives clinic might disrupt the team I am part of and would require significant input from the already over-stretched managers. I realised that when my research was completed, it would be highly unlikely that such a service would continue after my contract ended. For these reasons, I decided against this project.

3. The pilot project

After hearing about the under-fives pilot project, I wondered if researching it would be a more efficient method of studying early intervention in under-fives. I spoke with the clinical and operational leads, and their aim to bring together experienced staff already working in the county to establish a sustainable, county-wide service under a ‘Steering Group’ intrigued me.

In my research I learned that substantial numbers of young children and families need specialist mental health support, but do not meet CAMHS criteria. The result is that under-fives workers and infant mental health professionals tend not refer to CAMHS as they know the current focus is on assessing and treating patients at higher levels of risk. I learned

under-fives workers often feel overwhelmed and out-of-depth when trying to support young children and families but had no specialist organisation to refer to.

I reflected on my own previous experience of working as a pre-school teacher in a Montessori school, as a teacher in an employability project for adolescents with autistic spectrum conditions (ASC), as a manager of residential care settings for adults with ASC and learning disabilities and as a CAMHS clinician. In my experience, early intervention had often proved life-changing, especially for very young children. Families who do not receive timely support are at risk of poorer outcomes and may become *'locked into an unhelpful pattern of relating, feeling persecuted and being persecuting'* (Wittenberg, 2008, p. 36) with corresponding costs to society in the longer term. Wittenberg adds that early intervention means a little help can be highly effective in facilitating meaningful change, which is well-supported in the literature, including Balbernie (2001), Onions (2009), Murray (2014), 1001 Critical Days: The importance of the Conception to Age Two period, (Cross-Party Manifesto, 2013), The Future in Mind document, (Department of Health, 2015) and the Rare Jewels report (Parent-Infant Foundation, 2019).

I then spoke to the local managers of CAMHS and CAMHS-Learning Disability teams to improve my understanding about how referrals for children under five were processed by the Early Help Hub that directs referrals to CAMHS from parents, carers and under-fives workers. I felt shedding light on the phenomenological experiences of under-fives workers who had used the pilot project could be helpful in contributing to creating a high-quality service that considers the needs of professionals as well as those of families.

Overview of the pilot project

The aim of the pilot project was to create the first parent-infant mental health service in the county, to become part of a larger county-wide integrated under-fives mental health service, in line with the NHS long term plan (National Health Service, 2019). It was set up by child psychotherapists and shares the ethos of the Tavistock Under-Fives' clinic and the Parent-

Infant Project (PIP) at the Anna Freud Centre where the focus of the treatment is the relationship between the parent(s) and their baby or child.

The pilot project aims to improve parents' confidence and their capacity to understand their child's communications, so they are more able to enjoy their relationship. It follows the iThrive model which foregrounds the importance of therapeutic and professional relationships to provide quality care and support to patients. It supports professionals, both in the National Health Service (NHS) and in other sectors, who work with children under five and request professional support for more complex cases.

The pilot project was overseen by a multi-agency Steering Group and was chaired by the local Maternity System lead and attended by lead professionals from Child and Adolescent Psychotherapy, Educational Psychology, Perinatal Mental Health, Council Commissioning Service, Health Visiting, Midwifery, Special Parenting and a peer user with lived experience. The ethos of the pilot project is to work closely with existing services and to bring together experts from across agencies to form the multidisciplinary Consultation Group. The Consultation Group is at the heart of the pilot project and is made up of a flexible core group of mental health specialist professions in the early years system, including Educational Psychologists, Health Visitors, Perinatal Mental Health Workers, Primary Mental Health Workers, Learning Disability Nurses, Early Help Workers and Child and Adolescent Psychotherapists. The Consultation Group meets once weekly for two hours. Under-fives professionals whose referrals have been accepted by the Early Help Hub are invited to present cases to the panel. At the time I carried out the interviews, it was taking at least six weeks from the referral being made to the understandings being received by the referrer.

The following is an overview of the referral process:

- The referrer gains consent from the family they wish to discuss
- The referrer completes a Maternal Object Relationship Scale (MORS) with the parent or carer

- The referrer completes a CAMHS Early Help Hub referral form and sends it to the Early Help Hub, including the contact details of any practitioners in the network that they want in the consultation
- If the Early Help Hub and pilot project accept the referral, the date of the Consultation Group meeting is emailed to the referrer
- The referrer attends the Consultation Group and presents the case, alongside the practitioners they have asked to attend
- Following the consultation, a copy of the Consultation Group's integrated 'understandings' is sent to the referrer, which contains their understanding of the situation and information on what may be helpful for the family
- The referrer can contact the pilot project to talk through the understandings before feeding back to the parents
- The referrer explains the Consultation Group's understandings to the family

The pilot project was designed for parents and carers who are facing the following situations:

- struggling in relationships with infants and children under five
- struggling to feel emotionally connected with their infants or young children
- whose young children struggle to separate
- where past experiences are impacting on parenting
- where there are concerns about an infant or young child's emotional development
- mothers who have experienced difficult pregnancies
- families who have experienced trauma

The pilot is based on the Solihull Approach, a theoretical model designed by child psychologist and psychotherapist Hazel Douglas and collaboratively developed with the Solihull Health Visitors. Douglas and Johnson (2019) state that the aim of the approach is to improve the emotional health and wellbeing of parents and their children by integrating psychoanalytic theory (containment), child development research (reciprocity) and learning theory (behaviour management). The Solihull Approach highlights links between behaviour

and emotion, focusing on the parent`s and children`s emotional regulation to improve practitioner-parent and parent-child relationships, which is consistent with viewing the 'relationship as the patient' at the heart of under-five's work.

Alongside the theoretical model, the Solihull training foregrounds reflective practice as fundamental to the emotional health and wellbeing of under-fives workers. Reflective practice supports practitioners to step back, consider the range of emotions they are feeling and to develop a more profound insight into the impact the work with young children has on them and that they have on the families they work with.

4. The structure of the thesis

I begin with a literature review exploring relevant literature focusing on parent-infant and under-fives' psychotherapy.

Secondly, I explore the methodology of my thesis and my choice of Interpretative Phenomenological Analysis (IPA) as the most suitable methodology to structure my research. I then investigate the sample, inclusion and exclusion criteria, data collection methods and the subsequent analysis of these data and reflect on my research journey.

Thirdly, I present the findings from my interviews.

Fourthly, I discuss my interpretation of the data from my research.

Lastly, I present the conclusions from my analysis of the data, consider what has been learned and make recommendations for further practice and study.

Chapter 2 - **Literature review**

I have used a systemic approach to carry out the literature review with regard to searching, appraisal and re-analysis (Aveyard, 2019). While a complete systematic review is beyond the scope of this project, I have used systematic principles to provide a comprehensive review of the relevant information with regard to answering my research question by developing my '*own hierarchy of evidence*' (Aveyard, 2019, p. 68).

To find relevant studies and books, I made use of journal and book searches across databases including PsycINFO, EBSCOhost, and Pep-web Archive and the Tavistock and Portman Library webpage. My search items included: 'work with under-fives', 'parent-infant psychotherapy', 'infant observation', 'parent-child psychotherapy', 'child development' and 'the parent-child relationship'. These searches led to various books and journals, including the 'Journal of Child Psychotherapy', 'Journal of Clinical Psychoanalysis', 'Infant Mental Health Journal', 'Child Development', 'International Journal of Psychoanalysis' and 'Infant Observation'.

My database searches uncovered a large amount of literature which required the use of Boolean operators and search limiters to reduce the number to relevant articles and books. Of the remaining articles, I read the abstracts and decided which research was relevant in answering my research question. However, I understand that literature reviews are essentially living documents that are never completed, but need to be updated with new data, when relevant (Aveyard, 2019). As no single strategy provides all the information to answer the research question, I used hand searching and snowball sampling (Greenhalgh & Peacock, 2005), where the sampling strategy evolves according to the needs of the research and considers previously used literature.

I have separated the literature into nine sections to provide a comprehensive and systematically organised review.

The first section explores the parent-child relationship and parent work from a psychoanalytic perspective. The second section investigates the intergenerational transmission of relationship patterns from mothers and fathers. The third section considers the practice of how infant observation informs under-fives work. The forth section provides an overview of under-fives services. The fifth section explores the models of intervention in under-fives' work, focusing on brief work and consulting to the network and considers neuroscientific influences on psychotherapy. The sixth section investigates the place of males in under-fives services. The seventh section considers the importance of a containing structure for under-fives' workers with regards to supporting mental health and creating a sustainable work environment for the long-term. Lastly, the eighth section outlines some important government policies and an independent report on parent-infant mental health.

1. Exploration of the parent-child relationship

Donald Winnicott, through close observation of mother-infant interactions as a paediatrician and psychoanalyst came to the opinion that:

> *There is no such thing as a baby … A baby cannot exist alone, but is essentially part of a relationship.* (Winnicott, 1964/2021, pp. 79).

Winnicott's statement elegantly captures the essence of parent-child work and foregrounds the importance of holding the parent-infant relationship in the forefront of our minds as psychotherapists. This is in line with Hopkins' view that there is no such thing as individual psychopathology in infants; she believed that:

> *... symptoms in the infant can best be treated by treating the infant-parent relationship, rather than by treating either infant or parent separately*.
> (Hopkins, 2008, pp. 54).

Both Winnicott and Hopkins highlight the fundamental importance of viewing the presenting difficulties in the baby or young child in the context of the parent-infant relationship, rather than locating the issue in the child or the parent.

The importance of working with parents and children has been long understood and Hermine Hug-Hellmuth was possibly the first to apply analytic ideas to children's education in the 1920s (Blake, 2008). Hug-Hellmuth believes it was important that parents feel supported to be patient and understanding of their children`s disturbing behaviour and that parents often needed strategies to be able to accomplish this (Blake, 2008). Geissmann and Geissmann (1998) believe it is likely that both Anna Freud and Melanie Klein were influenced by her pioneering psychotherapeutic work with children. Although Anna Freud and Melanie Klien found little in common in their theoretical findings, they both:

> *…shared strong belief in the importance of the child`s imaginative life as developed in the matrix of family relationships and as expressed symbolically through play.* (Likierman & Urban, 2009, pp. 25.)

Winnicott (1960) suggests in Freud's work that while there are child observations, most notably the analysis of Little Hans (Freud, 1909) and the cotton reel game (Freud, 1920), his thoughts about infancy are primarily derived from the study of his adult patients in analysis. It can be argued that Freud neglected infancy. However, Freud acknowledged that the infant could not have come into existence nor maintain his or her life, without maternal care (Frosh, 2012). Freud (1926), when considering difficulties experienced in adulthood, emphasises the importance of the quality of the person's childhood and the relationship with his or her parents, thus highlighting the importance of early childhood relationships for the adult's wellbeing and development. Freud's view that many adult difficulties are rooted in childhood experiences and are often linked to early parent-child relationships has since become a core belief in psychoanalytic psychotherapy.

Klein expands on Freud's ideas of childhood, focusing on very early primitive developmental issues in children (Spillius, Garvey, Couve & Steiner, 2011). While Klein focuses on working with individual children, her work on paranoid-schizoid functioning and projective identification is fundamental to understanding the parent-child relationship as parents are frequently the recipients of primitive projections from their children and may also project into their children themselves. Klein (1926/1975) believes that children are also able to engage in psychoanalysis, based on the same principles as adult analysis, which was a radical idea at the time. Klein believes there is a closer link between conscious and unconscious processes in children than in adults, which facilitates unconscious communication. She maintains that play was the path to the inner world of children, a parallel to Freud's idea of dreams as the royal road to the unconscious in adults (Blake, 2008). It has been argued that Klein focuses too much on the inner world of the child and she has been criticised for not sufficiently taking the impact of environmental factors into account (Blake, 2008; Frosh, 2012).

Klein (1946) describes the ‘paranoid position’ as characterised by primitive anxieties about survival of the self. In Klein's view, the infant copes with intolerable anxieties by splitting off parts of the self and projecting them outwards, into the object or parts of the object, most likely the mother. The infant may then fear a retaliatory attack. The ability of parents to survive these attacks plays a central role in supporting their infant to move towards integrating feelings of love and hate to achieve the 'depressive position' (Klein, 1946). Hubbard and van Ijzendoorn (1991) maintain that distressed babies who are picked up and soothed by caregivers in their first year tend to cry less than babies who were not picked up. Joyce Roberston (1971) writes about the films she and her husband, James Robertson, made which clearly show the fundamental importance of maintaining emotional bonds between child and parent and the devastating effects of neglect or simply being separated from loving parents. If babies receive attentive support from loving and available caregivers and their emotions are understood and modulated, they are less likely to be overwhelmed by their experiences and incrementally learn to manage their own feelings, (Music, 2017).

Winnicott (1971/2005) encompasses this with his concept of ‘good-enough mothering’ where the caregiver makes active adaptions to the infant’s needs, graduated according to the infant’s evolving ability to tolerate frustration. Winnicott writes:

> *The good-enough mother, as I have stated, starts off with an almost complete adaption to her infant’s needs, and as time proceeds she adapts less and less completely, gradually, according to the infant’s growing ability to deal with her failure.* (Winnicott,1971/2005, pp. 14).

If the infant receives good-enough mothering and the environment is good enough, this contributes to growth and development in the infant, the child, and the adolescent so that adulthood can be reached (Winnicott, 1971/2005).

Bion's work on containment and projective identification to uncover the complex interactions of the infant with its parents or carers builds on Klein’s theory and supports a more nuanced understanding of parent-infant relationships (Blake, 2008).

Bion (1962/2019) believes projective identification to be crucial in communication in the infant-mother relationship as an attuned mother ‘feels’ her baby’s anxiety in a primitive form of identification. Bion suggests that early emotional states are experienced concretely and as such, are not yet emotions and not yet available for mental growth. The infant’s immature system is full of intolerable sensations that he or she can only cope with by projecting them out, most often into the mother to contain (Bion,1962/2019). If the mother is able to recognise her baby's feelings of distress and to experience their overwhelming and terrifying quality, she is capable of understanding the baby’s experience in the moment. The mother can then process this distress with her more mature psychic system, reflect, digest these feelings and transform them into something that can be thought about. The mother then feeds these digested feelings back with a response that her infant can tolerate (Onions, 2009). This provides opportunities for the infant to begin to internalise this capacity and over time, begin their own development of an inner world. However, if the mother or caregiver is unable to take in or mentalise (Fonagy & Target, 1998) these feelings, the infant is left with

overwhelming sensations or feel they are being attacked by angry projections from the mother. Gianna Williams (1999) likened this experience to introjecting a disrupting and fragmenting 'omega function' rather than a helpful alpha function that organises and creates links. As emotional states in infancy are often felt to be overwhelming, the infant may be threatened with feelings of falling to bits (Rustin & Emanuel, 2010). Bion writes, '*An emotional experience cannot be conceived of in isolation from a relationship*' (Bion, 1962/2019, p. 42), which is in line with Winnicott's (1971/2005) view that responsive early maternal care gives meaning to early experiences and to the physical and psychical survival of the infant. The mother's attentive relationship, openness to her infant's primitive somatic communications and ability to understand and then relive the distress the infant feels, is the unconscious process Bion (1962/2019) called 'reverie'. This is the infant's first experience of containment (Rustin & Emanuel, 2010).

Winnicott (1971/2005) felt the three primary maternal functions were 'holding', 'handling' and 'object-presenting'. Winnicott believes that if the mother's emotional holding and sensitivity helps the infant to feel at ease, the psyche is then able to 'indwell' in the body, giving rise to an easeful feeling of 'going-on-being' (Winnicott, 1965). Music (2019,) writes that many infants do not experience this feeling of safeness and that the feeling of just 'being' is interrupted by internal or external impingements. These infants therefore need to develop alternative ways of holding themselves together.

Esther Bick (1964) writes about the new-born's extreme vulnerability, their need to feel held together and to be protected from fears of falling apart or of falling into a bottomless hole. Bick believes the new-born is assailed by continual experiences of unintegration as he or she lacks a sense of their body being held together by a 'skin-container'; this can be mitigated by both the mental and physical holding that a containing mother can provide (Rustin & Emanuel, 2010). However, mothers are having to deal with the massive responsibility of sustaining their new infant's life and are themselves in need of containment in the form of practical and emotional support from their partners and network in order to

perform their ‘primary maternal function’ (Winnicott, 1971/2005). Bick (1964) writes that repeated contacts with a caring mother is emotionally nutritive and over time helps the child to form an internal mother, which Bick theorised as creating a ‘psychic skin’ the infant can grow into and make their own. Unfortunately, due to external difficulties, the mother’s internal struggles or the constitutional makeup of the infant, the ability to take in what the mother provides may be hampered. This may leave the infant without the experience of a thoughtful and containing adult to help them process difficult emotions, causing the child to develop alternative ways of coping and of holding themselves together. Bick (1968) described this kinetic activity, sensory stimulation, or excessive muscular development as a ‘second-skin defence’. The infant may then turn away from the carer, becoming prematurely self-sufficient, which may manifest as insecure or disorganised attachment and becoming controlling or rigid (Music, 2017). Murray writes that babies are utterly dependent on others for their survival and that the quality of this care has, *‘…profound and long-lasting effects on their development.’* (Murray, 2014, p. 7). A mismatch in the early parent-infant relationship, whether due to the quality of parental care or the infant’s temperament and responsiveness to the caregiver, can have serious and far-reaching consequences for the infant.

2. Intergenerational transmission of relationship patterns

Salzberger-Wittenberg (1970) writes that the birth of a baby may arouse infantile feelings in parents and that unresolved experiences from the parents’ lives may affect both their ability to bond with the baby and how the baby’s attachments develop.

Additionally, there may be Oedipal difficulties that arise in the parent-infant relationship with the arrival of a new baby. Britton (1998) proposes that if the infant can tolerate the link between their parents, he or she increasingly becomes aware of being a witness and not a participant, creating a ‘third position’. It is from this ‘third position’ that the ability to develop understanding and empathy can occur. However, if parents have unresolved Oedipal issues of their own, feelings of being left out may become intolerable and problems in the parent’s

past relationships might arise in their relationship with their partner and their own baby (Britton, 1998). Working with parent(s) alongside the child provides the opportunity to observe the family and to think about current problems and also the transgenerational and longer-term challenges within each parent and their family history (Emanuel & Bradley, 2008).

Louise Emanuel writes that parents may access services and wish for quick, practical strategies so their lives revert to normal and that an emotional reason for the somatic expression of their children's problem '*may not have occurred to them*' (Emanuel, 2012, p. 278). This highlights the lack of awareness some parents may have about how their own histories affect their experience the world and how they relate to their children.

Emanuel (2011) maintains that parents fall back on their own childhood experiences as a foundation for their parenting approach and may repeat cycles of abuse or neglect with their children. This process was explored in the seminal paper, 'Ghosts in the nursery', in which Fraiberg, Adelson and Shapiro (1975) describe how a symptomatic infant may be the recipient of negative projections from their parents. This paper uses object relations and attachment theory to understand how the parents' histories may cause problems in their relationships with their baby. It also makes use of developmental guidance to support parents emotionally, so they are able to better observe and consider possible reasons for their child's behaviour (Hopkins, 2008).

Fraiberg and colleagues (1975) consider factors that may indicate the likelihood of the conflicted pasts of the parents being repeated with their own child. They find that simply having adverse experiences does not predict the repetition of the past in the present, nor can being exposed to pathological figures predict identification with those abusive figures. Specifically, they find that:

> *... the events of childhood abuse, tyranny and desertion was available in explicit detail. What was not remembered was the associated affective experience.*
> (Fraiberg et al., 1975, pp. 419.)

In essence, Fraiberg and colleagues (1975) find that parents could remember the acts of abuse, but not their feelings of helplessness, shame, anxiety, and terror of the experience, making the transgenerational repetition of abuse more likely. When the parents' repressed feelings could be acknowledged, re-experienced, and remembered in the safety of the relationship with the therapist, they were less likely to inflict their own childhood pain on their children. Moreover, they were more able to become protectors of their children against repetition of their own troubled pasts.

Fonagy and colleagues (1991) carried out a study aiming to 'measure the ghosts in the nursery'. This study administers the Adult Attachment Interview (AAI) which is designed to elicit the adult's account of their own childhood attachment experiences (Fonagy et al., 1991). In addition, the study uses the 'Strange Situation' technique to infer the nature of the child's internalised view of his or her relationship to the mother, specifically if the baby can rely upon the mother to alleviate his or her distress after a separation (Fonagy et al.,1991). This study found evidence supporting the view of Fraiberg and colleagues (1975) that parents with histories of abuse, deprivation or neglect are more likely to experience health, educational and psychiatric problems in themselves, with their children and in their family relationships.

Attachment research has shown that children are affected by earlier experiences. The Adverse Child Experiences (ACE) study (Felitti et al.,1998) finds a connection between long-term negative health consequences and ACEs: the more ACEs the child experiences, the higher the risk of problems in later life.

The findings from Fraiberg and colleagues (1975), Fonagy and colleagues (1991) and from AAI research indicate that it is not adverse experiences in themselves that are more likely to lead to transgenerational transmission of pathological patterns of attachment. The crucial factor is the parents' ability to provide a coherent account of their experiences, the capacity for reflective function (Hopkins & Phillips, 2009), together with appropriate affect. Essentially,

when adverse experiences can be remembered, they are less likely to be re-enacted for the next generation.

Music (2017) writes that parents preoccupied by unresolved childhood conflicts are less available to respond to their child's attachment cues and emotional communications and therefore make fewer mind-minded or attuned comments (Meins et al., 2013). As the infant cannot rely on his or her mother for help and has an immature psychic apparatus, repression is not possible, he or she may resort to a physiological strategy, such as the second skin defence Bick (1964), to reduce these negative affective states (Fonagy et al.,1991). Additionally, Fraiberg (1982) writes about a group of pathological defence strategies that she observed in infants between the ages of three and eighteen months which she maintains only occur in infants who have experienced extreme danger and deprivation: avoidance, freezing, and fighting/self-injurious behaviours.

Bion (1967/2018) writes that the infant has few options to express his or her anxiety and if the infant's projections are not digested by the mother, his or her fear of dying becomes denuded of meaning:

> *… the infant is reduced to continued projective identification carried out with increasing force and frequency.* (Bion, 1967/2018, pp. 115)

The infant then re-introjects a 'nameless dread', rather than a fear of dying made tolerable. The ghosts then start to gather in the nursery again and unhelpful attachment patterns are more likely to be transmitted to the next generation.

Pozzi-Monzo (2017) writes that when adults become parents, their own conscious and unconscious memories, good, abusive or traumatic, become part of their new relationship with their baby. Lieberman, Padrón, Van Horn and Harris (2014) suggest that moments of intense shared affect between parent and child, where the child feels loved, accepted, and understood by parents, provides the child with a core sense of self-worth which can interrupt cycles of maltreatment when these children become parents themselves. Lieberman et al. (2014) argue that these loving moments become `angels in the nursery` that act as a

counterbalance to the `ghosts in the nursery` (Fraiberg et al, 1975), which can promote a more nuanced appreciation of early relationships with primary caregivers.

This can prevent the cycle of identification with the aggressor (A. Freud,1993) where the abused person becomes the abuser, as perpetuating pain is used as a defence against experiencing it. Music (2017) believes that positive early attachment provides a buffer against later socioemotional blows and that secure attachment is built on the emotional sensitivity of parents` mind-mindedness (Mein et al., 2013) and their ability to mentalize (Fonagy et al., 2004). Essentially, the child being held in mind, being thought about, cared for and understood.

3. The fundamental importance of observation

Infant observation has been fundamental to the Tavistock child psychotherapy training since its introduction in 1948 by Esther Bick and John Bowlby (Rustin & Emanuel, 2010). The importance of infant observation was demonstrated in Freud's writing as early as 1920 in 'Beyond the Pleasure Principle' when he describes closely observing his grandson playing with a cotton reel. This well-known example of the 'fort-da' game has contributed to psychoanalysts and psychotherapists interest in using infant observation to inform our understanding about child development (Frosh, 2012). The films of James and Joyce Roberts facilitated a novel form of observing the reactions of young children separated from their parents on admission to hospital - a strange, frightening and unknown environment (Robertson, 1971). The knowledge gained from observing these infants fundamentally changed hospital practice in the 1960s and has been of considerable value to psychotherapeutic understanding.

Infant observation for the psychotherapy trainee entails the student going to the family home for an hour, once weekly from as soon after birth as possible for the first two years of the baby's life. The observer pays attention to what is happening between parents and infant in

the home and importantly, the emotional experiences the family are having, which they record after the session and then present at weekly infant observation seminars.

Lisa Miller writes about the two-fold importance of the student experience of infant observation:

> *First, the student gains highly privileged and detailed access to the processes whereby a child grows up emotionally, socially and intellectually within a family. Second, the student is enabled to develop the capacity to observe, and to observe in a rich and total sense.* (Miller, 2008, pp. 39).

This is in line with Bick's view that the purpose of infant observation was to '*help students to conceive vividly the infantile experience of their child patients'* (Briggs, 2002, p. 37).

In essence, infant observation allows observers to immerse themselves in the depths of the baby's experience of life and to gain insights into the fears of new-borns and their innate need to construct a psychic space in which to survive within their families (Bick, 1964). It also allows trainees to observe how the new infant impacts the family dynamics, which is a rich training ground for parent-infant and under-fives' work.

Rustin (1989) writes that the aim of observation is to observe, to notice and to be attentive, not to offer clinical intervention or advice. Salzberger-Wittenberg (1970) makes the salient point that as observers, we need to learn to separate and manage our emotions regarding what we witness and what these emotions evoke, due to our pasts and relationships with our own parents. A fundamental challenge for the student during infant observation is to recognise and hold the intense emotions that are evoked by what is happening between baby and parents and what this might evoke in us, while remaining an observer. Being part of the weekly seminar group with an experienced seminar leader is seen as vital in containing individual and collective anxieties and withstanding pressures to intervene or to 'know'.

Miller (2008) highlights the importance of the observer's emotional receptivity to others, their own emotional states and how they need to stay in touch with these primitive emotions and

anxieties. This evolving understanding of emotional states as an observer, in conjunction with an increasing understanding of psychoanalytic theory and our own psychoanalysis, allows us to recognise what we bring to the observations in terms of our own experiences and preconceptions that can interfere with our ability to understand what is really happening.

Observational skills in practice

In the evolution of the student into the qualified psychotherapist, the concepts that Bion (1962/2019) outlined about learning to stay in the moment, to hold uncertainty and to allow material to unfold in an unstructured way are crucial. Louise Emanuel (2011) writes about the importance of remaining receptive to observing how a family presents themselves in sessions and to remain aware of the personal emotional impact this has on the therapist by attending to countertransference experiences. Moreover, Emanuel (2012) writes about the concept of 'transformative moments', particularly in brief work, where the therapist observes a moment of emotional meeting that can lead to therapeutic progress. As the therapist remains present and 'in the moment', this allows what Bion (1962/2019) called the 'selected fact' to emerge, creating a clearer focus for the work. The focus placed on close observation of our young patients, and ourselves, enables us to experience how young children often dramatically enact their family predicament and their place in it through their interactions with the family and play in the sessions (Emanual, 2011).

Dilys Daws expands the concept of observation and demonstrates its nuanced potential in practice with her work in a baby clinic. Daws (1985) writes about placing herself in an optimal position to observe babies, mothers and fathers, and colleagues as she stands next to the weighing scales. Daws places herself optimally to observe parent-infant interactions and also intentionally places herself where she is observed by staff.

> *Standing by the weighing scales is a useful place to be – I am visible to the doctors, health visitors and noticing me helps them to notice which parents might need help with the emotions of being a new parent* (O'Rourke, 2018).

Daws' approach is relevant to the task of 'consulting to the network'. Her broader view of observation helps to keep a frame of analytic thinking alive in the minds of professionals in the larger network. 'Being seen' by staff in these situations facilitates the introjection of the 'thinking psychotherapist' by clinicians which over time and iteration may become a containing factor. There are parallels with Bick's (1964) view that repeated contacts with a caring mother is emotionally nutritive and over time helps the infant form an 'internal mother', which Bick theorised as creating a 'psychic skin' for the infant, or for infant mental health workers.

4. An overview of under-fives services

Contemporary CAMHS services have developed to consider the needs of both the parent or carer and child together, often in the form of parent sessions alongside their child's weekly or intensive psychotherapy. The aim of parent work or more focused parent-child psychotherapy is to work with the *'flow of conscious and unconscious communications'* (Emanuel, 2011, p. 673) from the parents and their children.

The Tavistock Clinic developed the Under-Fives Counselling Service in the 1980s and has seen families whose difficulties have arisen out of the ordinary experiences that occurred during the perinatal period. (Cudmore, 2007).

The Tavistock model offers families five parent-child psychotherapy sessions, with an additional five sessions if needed (Miller, 1992). The aim is to respond promptly and provide a brief and flexible therapeutic approach without creating an unhealthy dependency on the service. The success of the Tavistock approach facilitated parent-infant work becoming an accepted method of treatment for difficulties in early years work in the United Kingdom (UK).

Balbernie`s (1998) review of methods of intervention for parents and infants in America finds the common theme in the various approaches mirrors the relationship-centred focus in the UK.

> *What all these approaches have in common is that they aim to alter the interactions between parent and small child so that their relationship is improved, creating as secure an attachment as is possible in any given circumstance*. (Balbernie, 1998, pp. 17).

The Anna Freud Centre (2023) runs the PIP which helps families needing support with perinatal mental health problems. Neither the Tavistock nor the PIP focus on the child or the parent as the patient, rather the patient is seen as the troubled relationship between them. The aim is to understand the impact the baby has had on the parent(s) and the impact the parent(s) are having on the baby. The therapy at the PIP is open-ended for up to one year, the aim being the parents and therapist develop a trusting relationship as they watch the baby making sense of its world. Parents then have an opportunity to speak to the therapist about current issues in their lives or issues from the past that are affecting them, at a pace the parent feels is safe.

Parent-infant work has become more commonplace since the 1980s and there are far more organisations and charities providing support, often with a strong online presence. For example, The Association of Infant Mental Health (AIMH) has set up hubs over much of the UK and aims to promote the importance of infant mental health and to support the professional development of practitioners who work with parents and babies (Association of Infant Mental Health, 2023). The Parent-Infant Foundation (PIF), formerly Parent-Infant Partnership UK, aims to support the growth and quality of specialised parent-infant teams so that babies have a healthy foundation for their lifelong mental and physical health (Parent-Infant Foundation, 2023). The PIF focuses on sustainability and cost-effectiveness to ensure families can access long-lasting services that are clinically and organisationally robust. The PIF provides information about funding, the importance of being able to speak the language of managers and commissioners and measuring outcomes, all of which are vital if the service is to not only survive, but thrive (Parent-Infant Foundation, 2023).

5. Models of intervention in under-fives work

Barrows agrees with Fraiberg and colleagues (1975) that the task of psychoanalytically informed parent-infant psychotherapy is to:

> *… free the infant from the damaging, unconscious projections of the parent – to rid the nursery of its ghosts.* (Barrows, 1999a, p. 190).

In addition, Barrows (1999a) argues that ridding the nursery of its ghosts becomes achievable when parents have sufficiently developed their reflective self-function through creating a consistent narrative of their childhood and understand how their own experiences may be being re-enacted in the present with their own children.

Rustin and Emanuel (2010), describe the ways of working with under-fives' as consisting of three core facets. Firstly, brief work, which forms the basis of the Tavistock Clinic's Under Five Service. Secondly, longer-term work for more complex cases. Lastly, consultation to professionals and the network working with the parents. I have focused on brief work and consultation with the network for this study.

5.1 Brief work

Much has been written by clinicians including Watillon, (1993), Miller (2008) and Rustin and Emanuel (2010) about the potential for quick change within parent-child work in 'brief work', where families are offered up to five sessions, with the possibility of five more, if needed.

Hopkins writes:

> *The capacity for rapid change in infant-parent relationships is a reflection of the flexibility both of the infant and of his parents.* (Hopkins 1992, pp. 15).

Jones (2006) writes that in parent-infant work, the baby, parent and therapist are plunged into the reality of experiencing feelings of dependency, vulnerability and helplessness, which provides unique opportunities to focus on these difficult themes.

Pozzi-Monzo, Lee and Likierman (2012) add that during brief work, one of the significant aims is to transform the parents' persecutory perceptions of their child into a more benevolent mindset where their child is recognised as needing love and understanding.

The following example from Louise Emanuel's (2012) work in an under-fives service shows her responses to the child's communications and play alongside the parents' concerns. The parents brought their three-year-old daughter for brief therapy and seemed to be hoping for practical strategies to implement to help her use the toilet effectively, so they could return to their normal life. However, it became clearer to Emanuel that the young child's difficulties were linked to:

> *… a need to be held in mind and emotionally contained: she seemed to have developed a 'muscular second skin container' - her tight sphincter control - which provided the substitute holding she lacked, especially when unpredictable change of transitions occurred* (Emanuel, 2012, pp. 278).

Emanuel (2012) felt the parents were invested in perceiving the issue as a purely physical problem and that it had not occurred to them that their child might be holding onto her faeces to cope with her anxiety, alongside her place as the baby at home. Through her countertransference, Emanuel felt a sense of intense pressure and desperation and endeavoured to put this into language the parents could understand. She said that while the father felt he needed strategies to implement, he was expressing a sense of helplessness and that he wanted the professional to *'take away that unbearable feeling of helplessness'* (Emanuel, 2012, p. 279). Emanuel explained their child needed them to empty their minds of their own anxieties and to let in some of their child's feelings; to bear with them long enough to understand what it is to be really helpless.

On reflection, the parents recognised their initial desire for concrete strategies to take away and implement, but that the therapist helping the father to empathise with his daughter's feelings had been 'transformative' for them. In essence, this example shows how the therapist's ability to provide containment for parental anxiety enabled parents to be in touch

with their child's terror of losing control and feeling helpless, recognising *'the infant in the child and the child in the adult'* (Emanuel, 2012, p. 283), leading to the crisis being resolved in very few sessions.

Neuroscientific influences on psychotherapy

Cramer and Palacio-Espasa (cited in Barrows, 1999a, p. 191) believe a further benefit of brief work is the greater openness to change that exists in the perinatal period, due to both the parents' and infant's ability to adapt. Rustin and Emanuel (2010) write that the thrust of the young child's development is a significant contributing factor in their ability to change so rapidly. This can be partly explained in terms of the neuroplasticity within young children. We understand the brain is most primed for growth and development within the first two to three years of life, thus creating a significant potential for change. Hopkins (2008) maintains that in the first two and a half years of a child's life patterns remain unfixed and she believes there is *'a remarkable behavioural flexibility'* (p. 65). In support, Schore (2012) writes that the significant plasticity of the infant brain means that symptoms and patterns of behaviour are flexible, and rapid change can occur.

Balbernie (2001) states that poor care adversely affects the infant mind, but he believes there is also an opportunity for stopping damage from dysfunctional parent-infant relationships and repairing the relationship, particularly with early intervention. Balbernie (2001) maintains that the time for greatest influence, for good or ill, is when the brain is new.

Advances in neuroscience have direct implications for parent-infant psychotherapy and under-fives work, providing a new understanding of brain development and the effects of trauma. Solms reminds us that Freud was originally a neuroscientist and that he:

> *… only reluctantly abandoned neurological methods of enquiry when it became clear to him, somewhere between 1895 and 1900, that the methods then available were not up to the task of revealing the physiological basis of the mind.* (Solms, 2021, pp. 32).

Solms (2021) writes that Freud believed at the time he was working it was necessary to use psychological methods, but that in the future neuroscience would become important in understanding the human mind. Solms (2021) argues that Freud is now being proved to be correct in this view.

Ricky Emanuel (2021) writes that a knowledge of contemporary neuroscientific research supports clinicians by improving their understanding of patients who have experienced trauma in infancy. Music explains that the prefrontal cortex is linked with tasks such as *'inhibiting impulsiveness, executive planning, empathy and interpersonal skills'* (Music, 2019, p. 59). Music (2019) maintains that if this area of the brain is underdeveloped, we may see children who struggle with their self-regulation and self-control and for whom managing relationships and communicating feelings is a challenge. These children may experience symptoms of hyper-reactivity, hypervigilance, and ostensibly unprovoked outbursts of aggression.

Lisa Feldman Barrett (2017) has put forward an intriguing bio-psycho-social model about 'how emotions are made'. Feldman Barrett's neuroscientific theory offers a nuanced and holistic understanding of the nervous system, which has profound resonances with the psychoanalytic theory of thinking. This has relevance for working with under-fives as it provides a better understanding of how trauma is experienced throughout the body, how memories are created and stored and how they can be triggered in the transference in psychotherapeutic work. Ricky Emanuel (2021) maintains that contemporary neuroscientific knowledge necessitates changes in our techniques, and that change is difficult, unwelcome, and is often experienced as a threat. This seems particularly true when considering body states and interoception in psychotherapy sessions, thus straying from the internal world of the patient in psychoanalytic psychotherapy. Ricky Emanuel sums up the predicament of incorporating contemporary neuroscientific research into traditional methods of working:

> *It is imperative, in my opinion, to do so. Not only for the benefit of our patients, but also so that therapists feel better equipped to treat the traumatised patients they*

> *see, which will help them feel less demoralised by the task they face. We have to allow our views to evolve in the light of new understanding and thus to learn from experience.* (Emanuel, 2021, pp. 399).

Parent-child relationship

There is strong consensus that the parent-child relationship is central in under-fives' work, particularly the processes of communication between the family members (Barrows, 2004; Jones, 2006; Hopkins, 2008). Parents become filled up with feelings of panic and falling apart projected into them by their baby and may struggle to recognise these confusing feelings as actually belonging to the baby (Emanuel, 2012).

> *It can be a relief when parents are helped to recognise that they may be the recipients of their child's unwanted feelings of infantile helplessness and confusion.* (Rustin & Emanuel, 2010, pp. 89).

There is something fundamentally important about providing a preventative approach and early support to parents, addressing problems quickly, before they become entrenched. Wittenberg (2008) writes that parents of infants are prone to feeling helpless, inadequate, persecuted, and guilty. When there is no one to unburden themselves to, these emotions escalate and become overwhelming. Wittenberg believes parents need a counselling service where they can examine the difficulties their infantile and destructive feelings may be causing, without feeling judged or infantilised by an expert. She writes:

> *It is always a surprise to me how even a little help at this early stage can go a long way and that this can prevent problems getting established and becoming a serious interference in the relationship between the couple and their baby.* (Wittenberg, 2008, pp. 37.)

Barrows (1999a) argues that another reason for the effectiveness of brief interventions is the greater openness to change during the perinatal period driven by parental wishes to provide good quality parenting experiences and to avoid repeating mistakes from their own pasts. Barrows adds that once improvement is noticed in the child, the parents' self-belief in their

ability to parent successfully is enhanced and their motivation to continue working psychotherapeutically is likely to diminish quickly, possibly leading to 'brief serial treatment' (Stern, 1995), where parents consult repeatedly, but briefly, particularly around developmental milestones. This can support issues related to developmental stages to be worked through at an age-appropriate time.

This serial work supports both Emanual and Bradley's (2008) and Wittenberg's (2008) views about brief work being flexible according to need, which is less likely to create an unhelpful, long-term dependency on professional advice. Rustin and Emanuel outline the importance of brief work:

> *… relatively brief periods of intensive treatment with young children can quite often resolve apparently intractable difficulties, and free them to get on with their lives.* (Rustin & Emanuel, 2010, pp. 95).

It seems the efficiency of brief work has made it popular with both families and NHS management due to time saving and financial reasons (Rustin & Emanuel, 2010), as difficulties can sometimes be overcome in within the five sessions offered. Barrows writes:

> *Such accounts can seem almost magical: the therapist is left in despair or puzzled – the family return next time and all is resolved!* (Barrows, 2003, pp. 283).

5.2 Consulting to the network

Rustin and Emanuel (2010) believe that under-fives work is particularly interesting to child psychotherapists because of the centrality of infant and young child observation in their professional training. Importantly, there has been an increase in infant observational and training courses for people working in infant mental health, including those involved in early years education, hospitals, health visiting, and community paediatrics. This multi-disciplinary approach creates a rich opportunity for joint thinking between community-based workers and psychotherapists, which is modelled by the Consultation Group in the pilot project. Rustin and Emanuel write:

> *… it simultaneously enriches the skills of a range of professionals and provides help to their clients.* (Rustin & Emanuel, 2010, pp. 89)

The effect of unconscious processes on the network

Freud was the first to realise that the patient`s emotions can be transferred to the therapist in the early 1900s, which revolutionised psychoanalysis and our understanding of how people communicate. Freud maintains the transference represents the patient's unconscious projection of feelings and emotions onto the therapist or other significant people in the patient's life (Freud, 1923). Significantly, Freud believes that it is impossible for the analyst to block all conscious and unconscious thoughts about the patient and he calls this pathway between the analyst and patient the 'transference neurosis' (Newell, Nelson-Gardell & MacNeil, 2016). The process by which the patient's thoughts and material is passed to the analyst and which activates the analyst's own unconscious, and as yet unresolved childhood conflicts, came to be known as 'countertransference'. Building on the countertransference, some years later Klein introduced the concept of projective identification, which is defined by Laplanche and Pontalis as:

> *… a mechanism revealed in the phantasies in which the subject inserts his self – in whole or in part – into the object in order to harm, possess or control it.* (Laplanche & Pontalis, 1973/1988, pp. 356).

Gianna Henry's (1974) paper 'Double Deprivation' provides illuminating insights into unconscious defences and the trauma and disturbance caused by abuse and severe deprivation in children and families. She explains the first deprivation is caused by external circumstances and is out of the child's control, while the second deprivation comes from the child's internal sources due to their mental and emotional defences, which prevents the child from utilising the help and support offered to them.

The term 'triple deprivation' is in line with Britton's (1981) thinking about how primitive unconscious mechanisms and defences against anxiety used by children and families get projected into care professionals and may get re-enacted in the care system. This might take

the form of unconscious attacks on linking that interfere with the professional's ability to think clearly or make use of outside help, thus mimicking what is happening in the family itself. Louise Emanuel's (2002) paper, Deprivation x3, describes the strong parallels with parents struggling to tolerate their child's projections and the great relief to professionals, social workers in this instance, when they recognise their feelings of distress or inadequacy may be emanating from the child or birth parents who are unconsciously projecting unbearable feelings onto professionals to tolerate on their behalf. Emanuel (2002) points out that in situations where the social worker must prioritise the child's needs while simultaneously attending to the child-like needs of birth mothers, the situation may become intolerable if a secure base from management is absent.

Early years teachers are highly likely to experience similar challenges when working with young children and their parents. Bowlby (2007) describes the care of young children as being complex and emotionally charged. Elfer (2012) maintains this creates an emotional burden for nursery teachers as they need to align their sometimes-differing personal beliefs of child rearing with their professional knowledge and responsibilities, while containing both their own emotional states and those of the young children they care for. Brennan (2014) describes the nursery teacher's role of containing distressed infants as emotionally draining and anxiety provoking. Significantly, Elfer and Page (2015) find that nursery staff may actively avoid awareness of the emotional and attachment needs of the very young children they care for by using defensive coping strategies, including distancing and detachment.

Bion's (1962/2019) concept of containment is shown in practice in these two instances, as nursery and social care management may be under pressure from senior management in their organisations, who are themselves under pressure from concentric levels of management and government. In practice, if under-fives workers experience the management level above them as frightened or frightening, rather than containing, the network is likely to become fraught with anxiety (Emanuel, 2002). If there is a lack of containment, this may lead to continuous forms of re-enactment from the base level of the

child and parents, up through the concentric layers of management and government, destabilising all concerned.

While all under-fives workers are constantly faced with unconscious projections and raw infantile emotions when working with distressed children and families, child psychotherapists have the benefit of analysis and supervision that are underpinned by psychoanalytic theory. This provides a rigorous framework to digest and make sense of the strong projections received from patients and the powerful countertransference feelings that may be experienced (Emanuel, 2011).

For instance, Pozzi (2003) writes of the disentanglement of mutual projections between the parent and child and Lieberman et al. (2014) write of the importance of untangling a tense and emotionally fraught situation between a mother and her young daughter. The ability to recognise and to have the courage to broach these complicated emotional entanglements is a core function of parent-infant psychotherapy. This illustrates the therapist`s ability to support parents and children who lost in the despair of pain and guilt to reconnect and to realise the possibility of repair. Pozzi writes:

> *… the counselling aims to bring the difficulties and symptoms into the here and now of sessions, where they can be explored, understood, linked to the present or past anxious and conflictual situations, and can be contained by the therapist.* (Pozzi, 2003, pp. 202).

6. The place of males in under-fives services

Barrows (1999b) argues that involving fathers in parenting and therapeutic work is crucial, but warns that fathers' contributions to infant mental health are often neglected by infant mental health clinicians, both:

> *… as a contributor to the generation of the presenting problem or as an aid to its resolution.* (Barrows, 1999b, pp. 334).

Barrows (1999b) believes this undermines the potential impact of therapy for the family. Salomonsson, Baradon and von Klitzing (2019) write that while fathers are often excluded from the consulting room, they cannot be excluded from the mind of the mother, nor the growing representational world of the child and therefore have a direct or indirect effect on therapeutic outcomes.

Stern (1995) stated in *The Motherhood Constellation* that the constellation of 'daughter-mother-mother's mother' is more significant than the Oedipus complex as a central organising principle for a woman's psychic life during the time she has a baby.

> *It is expected that the father and others will provide a supporting context in which the mother can fulfil her maternal role.* (Stern, 1995, pp. 174).

However, this essentially consigns fathers to a secondary supporting role and Barrows believes that this:

> *… significantly underestimates the father's influence and thereby reduces the potential for therapeutic intervention.* (Barrows, 1999b, pp. 334).

Moreover, Stern's view assumes the mother's capability to carry out her maternal role, which may not be possible if she is struggling with mental or physical illness. This places an unfair and unhelpful pressure on the mother as well as devaluing the father's influence or skill. Fonagy and colleagues (1991) showed there was no association between the child's relationship to one parent and the other. This is supported by Hopkins and Phillips (2009) who write that the infant`s relationship to the father cannot be predicted by the nature of his or her relationship to the mother, but instead reflects the qualities which the father has brought to the relationship. This differing attachment becomes highly significant in families where mothers are unable to adequately care for their babies. As Bick (1964) states, this is particularly true for mothers suffering with post-natal depression, where the father is needed to fulfil the maternal role, until the mother has recovered.

> *This supportive behaviour of the father seemed to be an important factor in the gradual improvement in the mother's closeness and tolerance towards the baby*. (Bick, 1964, pp. 560).

Barrows (1999b) maintains that the relative exclusion of fathers from parent-infant psychotherapy is often attributed to difficulties in getting fathers to attend sessions. However, Barrows (1999b) believes this neglect may have more to do with how the inclusion of the father makes clinical work more complex for both the logistical organisation and for therapeutic interpretation. In support, Salomonsson and colleagues (2019) write that working with both parents is uniquely challenging, because as clinicians we have to integrate not only the relationship with the child, but also the mother, the father and the parental couple. Clinicians have to find ways of working within several entangled triads, which is often uncomfortable. Significantly, the clinicians' own resistance to working with fathers may be attributed to difficulties in working with the couple or to logistical problems, and this may result in fathers being excluded. Salomonsson and colleagues (2019) write:

> *We acknowledge that the real thirds, the fathers, play an important role in development. We should include them, inviting them to participate and make our work appealing to them. What a challenge for our own triadic capacity! Are we ready to include fathers?* (Salomonsson et al., 2019, pp. 166).

Therapists might be unconsciously affected by their own unresolved family dynamics. This may lead to the therapist colluding with the parent they identify with or excluding a parent they find threatening (Salzberger-Wittenberg, 1970). This could result in re-enacting a pattern of object relations that resembles the dysfunctional and exclusory behaviour of the family where the cast might change, but the plot remains the same (Britton, 1981).

However, including both mother and father in parent-infant therapy assumes a supportive enough relationship between them, but the stark reality is that this is often not present. Jones (2019) states that the parent-infant therapist has to compassionately consider whether the father's involvement has a positive or damaging impact. This requires ongoing risk assessment to protect the infant and the mother by involving outside agencies, including

children's services, police, and Family Courts. This '*adds layers of systemic complexity'* (Jones, 2019, p. 51), and supports Barrows (1999b) and Salomonsson and colleagues (2019) contention that clinicians may avoid the increased complexity of including fathers in parent-child or parent-infant work.

The role of fathers is succinctly described in the following quote:

> *We cannot emphasize enough how important the fathers are to the success of family relationships and to their children's development.* (Cowan & Cowan cited in Barrows, 2004, pp. 414)

As well as fathers often not being well represented in the lives of their children in parent-infant work*,* very few men work in the early years sector. Researchers from Lancaster University and the Fatherhood Institute carried out the GenderEYE (Gender in Early Years) project to determine why men are so poorly represented. The GenderEYE project (2020) investigated how men are recruited, supported, and retained and found that despite the Department of Early Years Education (DfEE) setting a target in 1998 to increase the number of males in the UK early years workforce to 6% by 2004, almost 20 years later the number remains between 2% and 3%. The GenderEYE project highlighted the absence of overall strategy in recruiting and supporting male practitioners to work in early years settings to create a more gender diverse workforce. Moreover, as working in the early years is not put forward as a viable career option for males in career guidance at school, few boys consider it.

The GenderEYE project states that:

> *There is a strong recognition of an unconscious bias with the early year's recruitment process and the need for more diverse recruitment panels.* (GenderEYE, 2020 pp. 9).

Glass and Minnotte (2010), arguing for more equitable female representation in the general workplace state that more women are needed in decision-making positions to lessen rigid gender stereotypes and to hire more women. They write:

> *Furthermore, greater gender integration of decision makers, including those serving on the search committee, will reduce tendencies toward ingroup bias whereby the dominant group favors hiring members of its own group.* (Glass & Minnotte, 2010, pp. 221).

Both Glass and Minnotte and the GenderEYE study alert us to how gender inequalities in the workplace can be unconsciously maintained. This highlights the importance of taking active steps to reduce systemic ingroup bias and to promote a broader view of diversity and inclusion to reap the benefits of a truly diverse early years workforce. However, confronting these issues of gender inequality and the paucity of male clinicians in the traditionally female dominated early years sector can be painful and deeply uncomfortable to consider, as it highlights entrenched conscious and unconscious biases in the system. These issues are difficult to think about and may illicit both individual and group defences to alleviate the pain of thinking and realisation (Bion, 1967/2018).

Henri Tajfel (1970), writing about social identity theory, suggests that humans have an innate tendency to categorise themselves into `ingroups` and ‘outgroups’, essentially splitting (Klien, 1946) groups into ‘us and them’, ‘good and bad. Ingroup identity focuses on the similarities between group members, whereas the outgroup is experienced as different, other and potentially dangerous. Tajfel (1970) writes that being part of an ingroup offers both a sense of identity and self-esteem, thus directly impacting how the outgroup is perceived, which effects intergroup relations, group dynamics and the capacity for change. There is a tendency to view the actions of the ingroup more favourably than actions of outgroup members. Ingroup favouritism and outgroup derogation may then occur, as the outgroup is perceived to be a threat to the goals and status quo of the ingroup (Hewstone, Rubin & Willis, 2002).

Stevenson (2012) writes that a group or organisation consists of individuals in relationship to each other and that work-specific anxieties and individual-specific anxieties inevitably lead to conflict. Stevenson (2012) asserts that there is a tendency to

externalise conflict or to project negative feelings (Bion, 1962/2019) into the other. While this leads to temporary anxiety reduction in the individual, it stifles free thought, group creativity and group cohesion in the long-term. Stevenson (2012) suggests that when there is conflict in group relationships within an organisation, or what Bion calls a challenge in the work task, it indicates a failure of containment (Bion, 1962/2019). This situation makes unbiased thinking difficult, often resulting in a move from depressive functioning to more paranoid-schizoid relating (Klein, 1946). Phantasies of blame and attack may then be experienced as a concrete reality (Stevenson, 2012). The individual may then split and project unacceptable parts of the self into another person so that they are expelled and disavowed in phantasy. These feelings are then attributed to the recipient, who may then be perceived as foreign and frightening, leading to fears of retaliation (Klein, 1946).

When considering the place of male clinicians and the role of the father in under-fives services, the data show that maleness is sometimes viewed as an unwelcome complication (Salomonson et al., 2019), a potential threat (Jones, 2019) and often ignored, (Barrows, 1999b). However, Emanuel (2019) writes that the Tavistock clinic`s approach to brief psychoanalytic interventions views the parent-couple relationship as important and both mothers and fathers are encouraged to participate. Where this is not possible, the clinician`s focus is on supporting a mother to understand her child`s needs and for her to exercise both her maternal and paternal functions. This approach to psychotherapeutic intervention maintains that each parent embodies both a paternal and maternal function – a combined parental couple (Emanuel, 2019). This is in line with Bion`s (1962/2019) concept of container/contained, which incorporates a maternal function, characterised by tender receptivity to the child`s communications, and a paternal function, characterised by boundary and limit setting, structuring and insight into new ideas and initiatives (Emanuel, 2019). When in healthy balance, these qualities of receptivity and firmness, that are held in each parent, provide an effective containing

framework, allowing the family to flourish. In contrast, when these functions become unhealthily polarised, the framework may become either overly punitive or overly indulgent, neither of which is helpful.

Britton (1998) writes that over time the young child moves away from the exclusive relationship with his or her mother, and towards a more triangular relationship involving the father. Emanuel (2019) maintains that in the absence of a united parental couple, it is more difficult to establish this Oedipal triangle.

> *The resolution of the Oedipal situation through relinquishing the sole possession of mother and the acceptance of the parents' relationship with each other creates what Ronald Britton calls a 'triangular space.'* (Emanuel, 2019, pp. 120).

Britton (1998) maintains that if the infant can tolerate the link between parents, he or she has the invaluable experience of being a witness, not a participant. This creates a third position - a space that provides the opportunity for empathy and understanding to develop. However, this means the child, or under-fives clinician in this instance, may experience painful feelings of being left out or abandoned.

With regard to addressing the lack of male clinicians in the under-five sector, the danger of highlighting the current gender imbalance and the need to evolve is that it might be experienced as an unwelcome interruption of the mother-infant relationship by an appropriative and intrusive maleness. This could potentially lead to intolerable fears of the mother/female clinician being pushed out or replaced by the father, or male clinician.

Bion (1967/2018) writes that a person`s intrinsic capacity to suffer mental pain and frustration is fundamental to their ability to think and to tolerate uncertainty.

> *A capacity for tolerating frustration thus enables the psyche to develop a thought as a means by which the frustration that is tolerated is itself made more tolerable.* (Bion, 1967/2018, pp, 112.)

Bion argues that a person`s incapacity for tolerating frustration makes the evasion of frustration a more likely means of coping with difficult thoughts. It seems that an aversion to actively considering the issues of the gender imbalance in the under-fives` sector may result in the unhelpful re-enacting a pattern of object relations that resembles the dysfunctional and exclusory behaviour of the family (Britton, 1981).

7. Mental health support for under-fives workers

A fundamental part of developing a sustainable under-fives workforce is ensuring there is a containing structure to support workers to understand and cope with distressing emotions this work involves. Emanuel (2011) writes that the framework for thinking about clinical psychotherapeutic work is founded upon a working understanding of psychoanalytic and attachment theory, child development research and practiced observational skills from infant and young child observations in our training. Emanuel goes on to speak about working psychoanalytically with young children and families:

> *In practice, it involves an ability to be receptive to the powerful projections via the mechanism of "projective identification," of parents and their children, as well as an ability to monitor one's countertransference responses to the family.* (Emanuel, 2011, pp. 674).

Bion's (1962/2019) concepts of 'container/contained' and 'maternal reverie' are foundational in psychotherapy training and child psychotherapists understand the young child's psyche is undeveloped and unable to contain the powerful emotions that are felt. In situations where a young child has been referred for professional help, both the child and the parent(s) need a 'caregiver' who is:

> *… able to "take in" and think about the child's unbearable states of distress without becoming overwhelmed by anxiety.* (Emanuel, 2011, pp. 674).

Both Bion's and Emanuel's thinking brings to my mind the issue of sustainability over time and staff mental health. While under-fives workers employed in social care, health and early years education are unlikely to be working psychoanalytically, they are nonetheless at the forefront of the raw emotion these situations generate. Berlin, O'Neal and Brooks-Gunn (1998) state that early intervention workers do intensive and emotionally demanding work and their ability to remain emotionally available and empathic depends on their training and work experience. Shonkoff and Phillips (2000) agree that the effectiveness of early intervention depends upon staff expertise and training, but also their ability to develop a personal relationship between the service provider and the family. I believe that staff effectiveness and sustainability is heavily contingent on managerial containment through understanding unconscious processes and facilitation of close working practices.

Newell and colleagues (2016) maintain there are three main terms used to describe the negative psychological reactions that health professionals working with traumatised people might experience: vicarious traumatisation, secondary traumatic stress, and compassion fatigue.

McCann and Pearlman (1990) described vicarious traumatisation as the potential cognitive changes in the therapist due to chronic exposure to and their treatment of other's peoples' trauma. This affects the therapist's sense of self and personally held worldviews, their fundamental beliefs in themselves, others, and the world around them.

Charles Figley introduced the term 'secondary traumatic stress' and defines it as the:

> *… natural and consequential behaviors and emotions resulting from knowing about a traumatizing event experienced by a significant other (or client) and the stress resulting from helping or wanting to help a traumatized or suffering person.* (Figley, 1995, pp. 7).

Figley (1995) maintains that secondary traumatic stress reactions are likely to result from engaging in an empathic relationship with a person suffering from a traumatic experience and closely witnessing the powerful experiences of their personal trauma. Figley (1995) writes that a person suffering from secondary traumatic stress can mirror the symptoms of post-traumatic stress disorder (PTSD) in the client or patient and potentially manifest PTSD symptoms, including intrusive thoughts, traumatic memories, insomnia, chronic irritability, avoidance of clients and client situations and hypervigilance.

Compassion fatigue describes the emotional and psychological fatigue that mental health professionals experience due to the chronic use of empathy when treating individuals who are suffering from experiencing traumatic events (Figley, 1995). Mathieu (2007) states that compassion fatigue significantly reduces an individual's capacity to feel and display empathy. This is important for infant mental health workers to understand as they are continually exposed to traumatic situations when working intimately with vulnerable mothers and babies who have been affected by adverse childhood experiences (ACEs) and economic deprivation.

The concept of professional burnout was born in the 1960s when social workers became responsible for large caseloads. I believe Freudenberger's thought-provoking description of professional burnout often reflects the experiences of infant mental health professionals, particularly those working in the NHS.

> *Nothing drastic had gone wrong in their lives … their job conditions hadn't noticeably changed. Yet, they now found themselves fatigued, depressed, irritable, bored and overworked. Each day they seemed to have less to contribute and more in the way of physical symptoms to cope with.* (Freudenberger, 1977, pp. 26).

Leiter and Maslach (1988) maintain that the process of burning out is a progressive state that occurs cumulatively over time and has three separate domains: emotional exhaustion,

depersonalisation and a reduced sense of personal accomplishment. Simply put, burnout is the result of too many demands and too few resources over too long a period (Demerouti, Bakker, Nachreiner & Schaufeli, 2001).

The concept of compassion satisfaction, in contrast to compassion fatigue, describes the pleasure people feel from working in helping professions and the positive feelings from making a meaningful contribution in people's lives (Figley & Stamm, 1996). Newell and colleagues (2016) write that the people who are suffering from trauma inherently require clinicians to use their personal psychological resources in the form of empathy and compassion to provide meaningful care. Radey and Figley (2007) suggest while the regular need to use personal reserves of compassion and empathy can be stressful, it is also a source of self-fulfilment and strength. Significantly, Turgoose and Maddox (2017) believe that higher levels of compassion satisfaction are likely to be a protective factor against compassion fatigue.

A survey of mental health professionals found many professionals working in the NHS feel their training does not equip them to work with young children and that they, *lack the skills and confidence to deliver parent-infant work effectively* (Parent-Infant Foundation, 2021, p.16). The report recommends that a workforce development strategy be created to ensure professionals are adequately trained and have the appropriate skills to provide critical services to all children across the UK equitably.

In this vein, Passmore, Hemming, McIntosh and Hellman (2020) advocate educating infant mental health professionals to make use of positive coping strategies and peer support, which they believe will reduce incidences of secondary traumatic stress and the risk of professional burnout. Bennett and Christian (2023) suggest emotional debriefing after difficult events might reduce the likelihood of secondary trauma and burnout and promote resilience. Nonetheless, the lack of staff confidence outlined in the Parent-Infant Foundation

report (2021) demonstrates that under-fives staff are feeling overwhelmed by a demand that continually outstrips their ability to supply adequate support, which is borne out in the Findings of this research project.

8. Government policy and independent reports

The following section provides a brief overview of some government policy and relevant independent reports focusing on parent-infant mental health and service development.

The 1001 Days Critical Days cross-party manifesto (Cross-Party Manifesto, 2013) foregrounds the impact of early experiences on brain development and on the lifelong emotional and mental health consequences this has. Moreover, it acknowledges the importance of the 1,001 critical days starting from conception until the baby is two years old in improving his or her life chances. There is a emphasis on improving the services for very young children and their parent(s) through a tiered system, identifying four levels of intervention. Tier 1 focuses on universal support, prevention and early identification; Tier 2 focuses on additional clinical and universal support for families in need; Tier 3 concerns specialist services where difficulties and a high level of need is already apparent; and Tier 4 refers to families with severe mental health problems requiring in-patient care. The 1001 Critical Days project focuses on early intervention with infants and parents and highlights the importance of multi-agency joint working.

Future in Mind: Children and Young People's Mental Wellbeing (Department of Health, 2015) explores how to improve the process for children and families to access support when needed and to improve the organisation and commission of these services. The document emphasises promoting good mental health through building resilience and early intervention. It emphasises the importance of strengthening the attachment between parents and their children to reduce the impact of early trauma by enhancing existing perinatal and early years services. There is a focus on transparent commissioning and training professionals to a high level, so they are more capable of supporting families in need.

Rare Jewels: Specialised parent-infant relationship teams in the UK (Parent-Infant Foundation, 2019) explains how Specialised Parent-infant Teams focus on early intervention and working at multiple levels to provide high-quality services to give babies the best start in life. At the time of publishing, there were only 27 teams in the UK, meaning most babies had no access to parent-infant teams. While CAMHS is meant to cover all children from 0-18 years old, the report found that in 42% of Clinical Commissioning Group areas in England, CAMHS services do not accept referrals for children under two-years old. The report highlights the importance of the first 1,001 days of life as foundational for later life and explains how persistent difficulties in early relationships may adversely affect children's development. It draws attention to the long-term costs of difficulties in early relationships to the individual, as well as to their families, their communities and society in general. The report explains that work with babies differs from work with older children and therefore practitioners need a profound understanding of child development, so they are capable of reading babies' pre-verbal cues. Moreover, these practitioners need to be able to work with parents and networks that support the babies.

The best start for life: a vision for the 1,001 critical days (Department of Health and Social Care, 2021) was commissioned by the Prime Minister and chaired by Andrea Leadsom MP. It focuses on the 1,001 days from conception to age two, when the baby sets his or her foundations for their lifelong emotional and physical wellbeing. This document has six action areas focusing on the Start for Life initiative that aims to improve the health of babies and children under five through healthier lifestyles:

- Seamless support and joined up Start for Life offer to families
- Welcoming family hubs where families can access Start for Life services
- Accessible information
- A skilled and empowered Start for Life workforce
- Continued improvement of Start for Life through evaluation and inspection
- Accountable leadership that can provide economic sustainability

Working for babies: Lockdown lessons from local systems (Reed & Parish, 2021). This report was commissioned by the Parent-Infant Foundation and emphaises the importance of the first 1,001 days in terms of both vulnerability and opportunity, as parents and babies are affected by their personal circumstances and the broader societal conditions of the time. While not a government policy, I have included this report as it provides insight into how the pressures of the Coronavirus pandemic have affected parent-infant services. It stresses the moral, social, and economic case for effective multi-service working to best support babies and families during the pandemic. This report has a more specific focus of looking into how local systems responded to the needs of babies and their families in the pandemic and lockdown, with the aim of learning lessons for the future. Reed and Parish (2021) found that babies' needs are often not prioritised by decision makers, despite the understanding there is an increased vulnerability in infancy and of the importance of early childhood development, calling it a 'baby blind-spot'. The report highlights the long-term issues that were exacerbated during the pandemic, but also the opportunities for change this unprecedented time has produced**.**

Chapter 3: Methodology

In this chapter I begin by discussing the research question and aims of my project. I then outline research design I have chosen, discuss the issues of validity and reliability and then consider how reflexivity is incorporated throughout the study. I provide information about the process of obtaining ethical approval before examining the sampling and recruitment aspects of my research. I consider the interview process, inclusion and exclusion criteria and discuss the process of data analysis and the importance of considering the effect of countertransference in IPA research. I conclude with my thoughts on the potential limitations of the methodology and my reflections on the research project.

1. Research question and aims

The aim of this research is to learn about the personal experiences of referrers using the under-fives' pilot project from referral to discharge to understand how they make sense of it. I am also interested in learning if the participants felt referring to the pilot project and being part of the Consultation Group had an effect on their own mental health.

2. Research design

Theoretical framework

This qualitative research project is based on the analysis of data that were generated through semi-structured interviews with four participants who referred to the pilot project. Two participants had also served as professionals on the Consultation Group panel, which I learned during the interviews.

I investigated a number of research methodologies for this project, including Grounded Theory (Glaser and Strauss, 1967) and particularly Thematic Analysis as it enables the researcher to identify, analyse and report the patterns and themes within the data (Braun and Clarke, 2006). However, I decided to use IPA as it was created to examine how people make sense of their lived experiences and the significance of these experiences (Smith,

Flowers & Larkin, 2009). IPA is an interpretative method informed by hermeneutics and views human beings as sense-making creatures. The participants' accounts are understood to be their attempts to make sense of their personal experiences. IPA is engaged in a double hermeneutic as the researcher has a dual role, which involves endeavouring to reflect on and make sense of the participants' thoughts, who are themselves attempting to make sense of their own situations (Smith et al., 2009). The IPA approach also allowed me to modify my initial questions in the light of interviewees' responses, and to actively pursue areas of interest that arose.

3. Validity and reliability

I found Yardley's (2000) paper, 'Dilemmas in qualitative health research', helpful when considering which qualitive method best suited my research project. I then used Smith and colleagues' (2009) interpretation of these qualities to consider the nuances of IPA in relation to the four essential qualities Yardley identifies, which I will now briefly explore.

In terms of the relevance for IPA research, Smith and colleagues (2009) focus on how Yardley's first essential quality, sensitivity to context, is shown through the interactional nature of data collecting when conducting interviews. Particularly in the endeavour to obtain high quality data and to ensure the participants' voices are clearly heard.

The second essential quality, commitment and rigour, is shown through the high degree of attentiveness paid to participants in the interviews. The process demands a thoroughness from the researcher in his or her attempt to make sense of how the participants attempt to make sense of their experiences. This essential interpretive element elevates the research from a description of the individual participant's themes as the researcher considers the themes they share through the lens of their own experience. I felt this method was well-suited to working psychoanalytically and conducting research in a reflective and meaningful way.

The third essential quality, transparency and coherence, supports the researcher to show as clearly as possible how the stages of the research process were approached and solved. In this study, my transparency about having previously worked with the two leads of the pilot project, who are both Child and Adolescent Psychotherapists, is a case in point. Smith and colleagues (2009) maintain that for good IPA research to be done, the phenomenological and hermeneutic foundations must be clearly apparent in the reading of it. The researcher should through his or her writing demonstrate their honesty in addressing the research for what it is 'in itself'. This is shown by the researcher attempting to make sense of the participants' experience through their personal understanding of the participants' individual and collective experiences.

Lasty, the fourth essential quality of good qualitative research is impact and importance. Yardley (2000) highlights the importance of the theoretical, socio-cultural, and practical elements of the work, which is at the heart of my aim for this research project - to create meaningful research that adds to the body of knowledge about improving the experience of under-fives workers referring to the setting. I hope the pilot project will be able to learn from my research and will be able to adapt their services where they see fit.

4. Reflexivity

Smith and colleagues (2009) write that a crucial component of IPA research is the researcher's focus on the process of reflection. Additionally, that the researcher's continuous and systemic self-examination to understand their conscious thoughts and lived experience is vital to carry out high-quality research. Brown (2006) writes that reflexive writing is an academic exercise, as well as an emotional undertaking. I found maintaining this balance in my research challenging at times as I endeavoured to portray the participants' feelings of frustration and idealisation, while continuously reflecting on what I was bringing to the research from my own biases and how this might affect the conclusions I have reached. I continually referred back to my research journal and to the notes I had made directly after the interviews when analysing the data, which commented on my countertransference during

the interviews. This helped me to reflect on how my own understanding was evolving on this research journey.

5. Ethics

Ethical approval

Ethical approval was gained through Essex University and the Tavistock and Portman Trust Research Ethics Committee (TREC) process (Appendix 1). Additionally, I got approval from the pilot project and from the Information Governance Department in my NHS trust to carry out the research.

Online interviews were mandatory at this time as face-to-face interviews were not allowed during the Covid19 pandemic. The approval process regarding online systems to conduct interviews and store data from the participants proved to be problematic. My trust uses Microsoft Teams and Attend Anywhere exclusively, while Zoom is considered a security risk and its use is prohibited. However, Essex University and the Tavistock only use Zoom to record research data and I was informed by the Tavistock that I had to use Zoom to conduct the interviews.

I followed the chain of command respectfully in each institution in my pursuit of a resolution, trying to find the balance between being too passive and being too active. As I was trying to get ethical approval from three institutions: my trust, the Tavistock, and Essex University, the process was exponentially more complicated and eventually became stuck. It became clear that people working at more junior levels lack the authority to make unilateral decisions or to be flexible and are obliged to follow their institutions policies. After exhausting all avenues to find consensus between the three institutions, I met with a senior member of the Academic Governace team in the Tavistock to explain the dilemma. She understood my predicament and granted me permission to use Microsoft Teams to conduct the interviews.

I returned to my research diary, which was helpful to revisit my state of mind at the time and the frustration I felt at being stuck in the space between three large institutions. I write:

> *It seems each system is speaking a different language and I lack the words to put the information into a way they can all understand and appreciate. It seems that each separate system is focused on protecting itself and that my research project is not seen as helpful or positive, more as a liability as it is difficult to control: it feels like an unnecessary risk for them and offers no reward. At times I feel powerless, directionless, and unclear about what I can do to find a resolution.*

I learned that conducting research is a complicated process and working with different institutions makes even relatively simple issues extremely complex. However, I understood the predicament the people I spoke to face as they cannot adapt institutional policy and they were stuck as well.

While this took six months to resolve, I did not let the delay derail my project and I started working on my Literature Review.

Ethical considerations

This project was not deemed to have high levels of risk, as I intended to interview under-fives workers, not NHS patients. However, it was still possible that during the interviews sensitive topics could be raised that might have caused distress.

I explained before starting the interviews that if a participant became upset at any point, I would pause or end the interview. This was also clearly stated in the information sheet (Appendix 2) and consent form (Appendix 3).

Consent was gained prior to interviews via the consent forms. I reminded the participants they could stop the process at any time, without needing to give a reason. I reminded them they could contact me later on should they change their minds about their interview being included in the study, up until their data had been processed.

If any safeguarding concerns had arisen during my research, I would have contacted the managers of the pilot project, my line manager and my trust's safeguarding team, depending on what was appropriate. It was clearly explained to participants in the information sheet and again before the interview that confidentiality would have to be broken if I had serious

concern about their own, or somebody else's safety, in line with trust policy and professional codes of practice.

6. Sampling and Recruitment

I consulted with my research supervisor, and we decided that four participants would be the ideal number as this would provide sufficient data to create a meaningful study, while still being manageable for me to analyse. Although my project has a small sample size, which limits the generalisability of the results, the focus of the study is to look at the lived experience of referrers and the strength of this qualitative project is its rich data. Reid, Flowers and Larkin (2005) maintain that 'less is more' in IPA and that fewer participants examined at a greater depth is preferable to a broader, shallower and descriptive analysis of a larger number of individuals.

Once I received TREC approval (Appendix 1), I contacted the Clinical Lead for the pilot project to ask her to provide me with names of professionals who had referred and had consented to being contacted for research. The Clinical Lead then contacted potential referrers and asked if I could contact them to discuss being part of my doctoral research project. This was not an ideal situation as the Clinical Lead may have been influenced by her unconscious bias to put forward only clinicians who she felt had positive relationships and experiences with the pilot project. I was given the names of six people who were interested in taking part and I chose four people who had different job titles to ensure as diverse a sample as possible. I contacted these potential participants via email and attached my information sheet and consent form. In the email I asked the potential participants to read the information sheet and to contact me if they would like to participate or wanted a discussion before making a decision. All four participants replied stating they wanted to take part and we agreed dates and times that would be convenient for the interviews.

The participants' pseudonyms are shown in the table below:

Table 1: Participant details

Participant's research name	Occupation	Gender	Had served as a member of the Consultation Group
Kirsten	Health Visitor	Female	Yes
Leyla	Educational Psychologist	Female	Yes
Daisy	Midwife	Female	No
Jasmine	Nursery school manager	Female	No

The interviews were done online and lasted between 30 to 60 minutes. I then sent a debrief letter (Appendix 4) via email in case the participants felt disturbed by the interview and needed to contact me, or my supervisor, if they were concerned about my conduct.

7. Interviews

I carried out the semi-structured interviews online using Microsoft Teams, according to my interview schedule (Appendix 5). I referred to the questions and prompts to give the interviews structure, while keeping the conversations open and flexible and supporting the participants to talk about what come into their minds, in the spirit of psychoanalytic psychotherapy.

After each interview, I wrote up my initial thoughts and reflections, then began transcribing the recordings when the material was still fresh in my mind (Appendix 6). These notes proved very helpful to refer back to when I was coding as it reminded me of the particular emotional atmosphere of each interview and allowed a more nuanced understanding.

8. Inclusion and Exclusion criteria

The inclusion criteria for participants to be eligible to take part were that they must have referred to the pilot project and also have been involved in the consultation phase. The exclusion criterion was that no referrer who had been dismissed from their posts would be eligible to take part.

9. Analysis

During the course of my research, I became aware that Smith, Flowers and Larkin had updated the IPA theory in a new book released in late December 2021. I researched and reflected on these changes which were mainly to do with terms regarding themes when coding. For instance, emergent themes are now called experiential statements, superordinate themes are now called personal experiential themes and master themes are now known as group experiential themes.

I discussed the situation with my research supervisor, and I decided to continue using the original terminology, which were still using in research seminars on the M80 course. I had started my doctoral research using the original terminology and I felt it would have been unnecessarily confusing to change at this late date. Importantly, the changes would not have added to the quality of my research and after consultation it was felt a change at this point may detract from it instead.

I then analysed the data, identified codes, and then eventually compiled these codes into superordinate and subordinate themes.

Finlay (2011) writes that analysis in IPA can be divided into two levels: first-order and second-order analysis. In first-order analysis, the researcher's aim is to develop a descriptive account of phenomena through the participants' eyes and to understand what it means to the participants through focused attention. In second-order analysis, the researcher moves beyond description towards interpretation by exploring the meanings that participants give to their stories (Larkin & Thompson, 2011) and by performing a double hermeneutic by attempting to make sense of how the participants make sense of their own experiences (Smith et al., 2009).

Finlay (2011) outlined the steps in IPA research, which I followed:

1. Reading and rereading – I immersed myself in the original data and wrote down my original thoughts in the margins (Appendix 6).

2. Developing emergent themes – I focused on chunks of the transcript and began to analyse the data and develop my notes into themes (Appendix 6).

3. Searching for connections across emergent themes – I began looking for links in the themes and began integrating the data.

4. Moving to the next case – I endeavoured to bracket the themes and content from the previous interview and remain open-minded, letting the data speak for itself as I repeated these steps for each interview (Appendix 7).

5. Searching for patterns across cases – I searched for patterns of shared higher order qualities across the interviews and took note of the emerging themes.

6. Interpretating at a deeper level – I began to analyse at a deeper level by employing the double hermeneutic of trying to develop a nuanced understanding of the sense the participants had made of their individual experiences.

10. Countertransference in research

While it could be argued that the use of the countertransference is not compatible with academic research, it is fundamental to psychotherapeutic practice as it allows therapists to develop deeper levels of understanding of what is being communicated between the patient and psychotherapist (Blake, 2008). Holmes writes that the countertransference can be used as an effective research tool and maintains that for the countertransference to be used effectively, the researcher is required to think and feel reflexively:

> *(a) to be able to observe behavioural and emotional changes in themselves and the participants; (b) not necessarily to accept their own or the participants' words or feelings at face value, but being able to 'feel around' responses and (c) an ability to examine potential links between observed changes in feeling states and other aspects of the research situation, such as changes in participant dialogue.* (Holmes, 2014, pp. 176).

Smith and colleagues (2009) state that IPA has been informed by three key areas of the philosophy of knowledge: phenomenology (the study of experience), hermeneutics (the study of interpretation) and idiography (the study of the particular). In essence, the IPA method offers, *'detailed, nuanced analyses of particular instances of lived experience'* (Smith et al., p. 37).

In my analysis of the data, I referred back to my research journal as well as the notes I made at the time of interview. I then reflected on my countertransference reactions at the time of interview to develop a more refined understanding of:

> *… how particular experiential phenomena (an event, process or relationship) have been understood from the perspective of particular people, in a particular context.* (Smith et al., 2009, pp. 29).

I found my countertransference provided insights into what might have been projected into me, how I was being experienced by the participants in particular situations and on my identification with the projections. By actively considering the transference and my countertransference feelings, I was better able to make sense of the data and '*thicken [my] understanding of the research process'* (Smith et al., 2009, p. 28), which I believe produced a more subtle and nuanced analysis.

11. Methodological limitations and considerations

While IPA is understood to be a flexible and versatile approach to investigating people's understanding of their experiences, it has been criticised for being somewhat ambiguous and lacking standardisation (Tuffour, 2017). Moreover, Willig (2008) argues that IPA may not provide a satisfactory recognition to the role of language, and that it depends on the participants' communication skills to communicate the subtilties of their experiences accurately. I kept this in mind in my endeavour to make sense of the individual participants sense making of their own experiences, the double hermeneutic. I was mindful that I am an immigrant to this country, and while English is my first language, there are nuances in

expressions that I may understand differently. English was one of the participants second language which gives weight to Willig's argument regarding the quality and nuance of the data depending on the ability to communicate emotive feelings effectively. A second criticism related to language is whether it is possible for IPA to accurately capture the meaning of the experiences that participants relate, instead of their opinions of it. I felt this was relevant in my research as the emotional timbre of the individual participant's recollection of referring in their interview will have been affected by events in their lives at that time and how the participants related to me personally and as a researcher. I believe taking the transference and countertransference into account offers a more profound understanding, ultimately producing higher quality research.

Lastly, IPA is a subjective approach to research which means that two different researchers will make sense of the data through their own lens of experience and will produce different interpretations and reach different conclusions (Smith et al., 2009). I feel this is both a strength and a limitation of IPA as a research method.

Chapter 4: Findings

In this chapter, I discuss the superordinate and subordinate themes that emerged during my analysis of the data.

1. **Reasons for referring to the service**
   - i- Referrers feeling overwhelmed
   - ii- Significant concerns about adverse parent-child relationships

2. **Experience of the service**
   - i- The referral process
   - ii- The consultation
   - iii- Professional diversity

3. **Outcomes from referring to the service**
   - i- Bespoke training for professionals
   - ii- Managing expectations
   - iii- Involving family members in the consultation process

1. Reasons for referring to the service

The pilot project is the first under-fives' service in the county. It provides support to parents who are struggling in relationships with their infants and children under five, particularly where parents own past traumatic experiences impact their parenting.

All the participants cited getting specialist direct work for families where they had concerns about the parent-child relationship as the primary reason for referral. One participant, who had previously served as a professional on Consultation Group panels, also sought expert consultation for themselves when they felt overwhelmed by holding the weight and complexity of a case.

i- Referrers feeling overwhelmed

The participants mainly reported feeling overwhelmed by cases where safeguarding was a risk. For instance, Jasmine, a nursery manager, wanted specialist strategies and advice to

support the mental health of a four-year-old boy. The nursery's trusted methods were proving ineffective in managing his violent behaviour towards staff and other children, which was destabilising the nursery.

Jasmine p5: *all strategies that were known to us, just, were not supporting his mental health and it was still escalating at home and at setting.*

The boy's carers, his grandparents, were at their wits end and were depending heavily on the nursery in the absence of other support, which put Jasmine and her team under considerable pressure to find a solution.

Jasmine p5: *there was just no support for them and everything they tried for the special guardianship and the local council, nothing. Nothing seemed to fit. That's the other reason we made a referral, to see if we could get support for them in the home as well.*

While safeguarding was the most common reason for referring, participants also sought support where the main concern was the complexity of the case. Holding this complexity alone became emotionally draining, as Leyla, an educational psychologist providing supervision to health visitors, suggests.

Leyla p7: *they (health visitors) can be holding these families in really complex situations where they're not concerned about safeguarding. You know that, that's not their main … risk, their main issue, but they're holding these families in really difficult situations and then there's a lot going on and it's really emotional and it's, you know, it's just hard.*

Participants spoke about feeling responsible for families on their caseloads, but not knowing how to support them nor having sufficient time to deliver meaningful change. The participants felt holding multiple complex cases increased the weight of their workload exponentially and led to emotional overload and over time, emotional burnout, which Leyla explains:

Leyla p6: *So I thought of [the pilot project] because it's such a wide team … would be able to bring some different viewpoints, maybe some different knowledge and experience. And kind of maybe a bit of shift because everything seemed very, very stuck*.

In addition, issues of secondary traumatic stress disorder, burnout and compassion fatigue appeared significant for participants as they all experienced the emotional duress from being exposed to the first-hand traumatic experiences of the children and families they supported. Kirsten, a health visitor, spoke about the stress from work affecting her personal life and mental health and her attempt to find solace and support by referring to the pilot project.

Kirsten p9: *that does affect me when I go home, obviously because it's kind of … I worry about what's going on, particularly with someone that's so fragile that it's like, you know, I don't know if she is gonna be alive tomorrow … kind of thing! So it's a yeah. It definitely affects you … definitely. It's a tricky one.*

Kirsten felt the stress from her job was affecting her family and had decided to leave her health visitor role, which she thought had become unsustainable.

Kirsten p50: *My husband's desperate for me for to leave the job. He's like … yeah … he's really keen 'cause he's seen over the years, he's seen the ups and downs that, you know, that I go through because of whatever's going on at work.*

Kirsten explained that after the experience of presenting to the Consultation Group and getting to know the team, she had applied for a job and would be working at the pilot project in the near future.

ii- Significant concerns about adverse parent-child relationships

At the core of all the participants' referrals were concerns about abusive family relationships, where intergenerational transmission of trauma and violent behaviour were significant factors and the parent-child relationship had become compromised. Kirsten referred the following case due to significant concerns around a mother's volatile, explosive and

dangerous behaviour directed at her two-year-old daughter that threatened her physical and psychological wellbeing.

Kirsten p2/3**:** *Mum would flit from being very lovely, sensitive, kind of wanting to be a really good mum at one moment, and then the moment something happened that she didn't agree with that she … I don't know, it just annoyed her. She just snapped … she [daughter] couldn't tell which mum she was going to get from one minute to the next.*

Kirsten felt this little girl's precocious speech development indicated she was developing prematurely as she had begun to assume aspects of the parenting role in an attempt to placate her mother and keep herself safe.

Kirsten p3/4: *she would say things like, "Don't … don't do that to me, Mummy. I'm only two!" and stuff like, "You make me scared," all this kind of stuff. She'd also suggest to her mum that she has a little rest because her mum seemed to need one. So, she'd say, "Why don't you lay down mummy and have a rest?" … which is really inappropriate for a two-to-three-year-old.*

Kirsten was concerned about the trauma being suffered by the little girl with regard to the confusion around the loss of boundaries in the relationship with the mother, the lack of parenting and containment and her continuing exposure to fear and insecurity. Kirsten developed a trusting relationship with the mother, who felt safe enough to confide her fears of hurting her own child and agreed to refer to get specialist support.

Kirsten p3: *And … she also told me that she was worried about what she was … would do, even though she didn't want to.*

Projection and negative attributions from mothers to their children were also a significant concern for participants. Leyla referred a mother of a boy whose father was in prison under a life sentence for murder. The mother believed her son was acting out and felt his behaviour was adversely impacting her other sons, who had a different father. The mother seemed to

be projecting the father's past onto her son, treating him as if he were already a violent criminal, not a little boy.

Leyla p4/5: *she'd often make comments about how the things he did reminded her of his dad. And you know, he could be quite violent and she'd just say, well, that's just like his dad. He's gonna turn into his dad. He's gonna end up in prison. He's gonna murder someone. And this is a four-year-old.*

Daisy, a midwife, referred due to concerns about the older sibling of a baby she was involved with. The boy's father had been physically abusive towards the mother in a past relationship and she seemed unable to make the distinction between her abusive ex-partner and her child: essentially, seeing the father in the son.

Daisy p3: *she was a survivor of domestic abuse and had a very difficult relationship with the father of that son. And it was very clear that to her he looked like his dad, and he was behaving like his dad. She'd already decided. And she was quite … it was very negative language around him. Including calling him … I think she called him [son] a dickhead at one point*.

Both Leyla and Daisy referred as they were concerned about toxic parent-child relationships where mothers were projecting their anger and hate for the fathers into their sons, who had started acting out in identification with these projections.

2. Experience of the service

i- The referral process

There was a feeling of frustration about a lack of feedback from the pilot project regarding expected waiting times once referrals were made. This lack of clear communication left referrers with a feeling of being left in limbo and having to hold both their own and their patient's hopes and expectations for an unknown length of time.

Leyla p10/11: *it would be helpful to know rough timescales, because I know … because … colleagues I've spoken to who I have recommended make referrals … when I kind of check in with them again, they say I've not heard anything back yet. And so, I don't know, when a referral was made, if they could get just send a response that says, 'the current wait list is approximately however many weeks or months, whatever it is, and we will contact you nearer the time'.*

The length of the referral process took far longer than participants and patients had expected. These long waiting times made referrals incompatible with the very short working remits of some participants, midwives in particular. As a result, some participants had to stay in contact after the patients had been discharged or had to delay discharge, as Daisy explains:

Daisy p7**:** *by the time we got the consultation with [the pilot project] the baby had been born and I was actually … I had already, you know, as midwives, we work with families for sort of four to six weeks postnatally and then discharge. So, I was not involved with the family any longer.*

The lack of communication about timescales and potential types of support being offered led to a disparity between the participants' somewhat idealised hopes and the support the pilot project could realistically provide. While referrers were unanimously positive about the experience of presenting to the Consultation Group itself, their primary reason for referring was to get what Kirsten termed 'actual one-to-one support' or what the pilot project itself refers to as 'direct work' (Appendix 8). It seemed the participants' overall experience of finding the pilot project helpful or not was largely contingent on patients receiving face-to-face support from a professional and less on the experience of receiving consultation.

Daisy p6: *I was … hoping for some meaningful intervention with the family and work with the family coming out of it. And I hadn't quite realized that actually it's very much about having a*

space to kind of discuss and look at what's going on within the family and from quite a … sort of psychotherapeutic perspective.

Daisy said the referral process had felt overcomplicated and frustrating as it took up time she could not spare.

Daisy p15: *I think it would be nice to have an easier referral process. … I think that is a real obstacle and it is time-consuming … and we just don't have the time.*

Daisy highlighted the referral form as an example of the time-consuming nature of the referral process.

Daisy p16: *even just the referral form … I guess, I don't know, but the reality is it is a barrier … and it will prevent some referrals being made, I think.*

Daisy felt the current process would become a barrier to future referrals, at least from midwives. Significantly, Daisy's referral did not lead to direct work for her patient, which is highly likely to have influenced her perception of the worthwhileness of referring. Her suggestion about using the Consultation Group as a therapeutic process in itself makes sense in this light and is discussed in following section.

When further work had been deemed appropriate there was an initial sense of relief that turned into a sense of disillusionment when the work had not begun months later (at the time of interview). This placed referrers in a difficult position as they felt a sense of responsibility to their often-overwhelmed patients and a sense of guilt for raising their hopes.

Kristen p6: *Well, we haven't … there's no work for anyone I've referred. The work hasn't started yet, unfortunately.*

These feelings of disappointment were somewhat mitigated by the understanding this was a pilot project and was not fully staffed. However, the ill-defined waiting period meant that anxiously waiting patients were on referrers' caseloads or in contact with them for far longer than their remits permitted, which generated stress for the participants.

ii- **The consultation**

The participants all described the experience of presenting to the Consultation Group as fundamentally helpful and cathartic.

Jasmine p22: *It was a really positive experience. I would definitely use them again if we needed to.*

The participants spoke warmly about feeling immense relief from being heard and contained by the diverse and experienced Consultation Group after sharing the weight and responsibility for their cases.

Kirsten p10: *I absolutely was blown away by how brilliant it was! I was really like, wow, this is such an amazing opportunity for a professional like myself to just dissect … have a child and, ah, one that I'm a bit stuck on and I'm not sure where to go with. And then and it was … I found it really useful, particularly as we're quite lone working as health visitors, you know. So we don't get that opportunity very much.*

The participants appreciated the bespoke advice from experienced professionals for their complex cases that felt stuck and overwhelming.

Daisy p11: *I mean, it's an amazing resource to have … to be able to talk through a family with such qualified and thoughtful people.*

The Consultation Group offered a place to share concerns about risk, seek advice from specialists and it provided relief in sharing the burden they had often been carrying alone.

Kirsten p17***:*** *it does give you a sense of relief and then you can walk through the rest of your day feeling a little bit like someone else's holding something for me. I'm not holding all the balls, you know, it's kind of … there is a sense of relief … when in any … whether it's [the pilot project] or … or social care or whoever. If someone says I'll work on that family with you. Then that just means you're doing it with a team as opposed to it on your own.*

The professional acknowledgement of difficulty, attention to detail and time taken in the consultation was experienced as uniquely validating and containing for participants.

Leyla p15: *I think … it feels quite validating that … to have that kind of questioning period and you know, other people acknowledging actually this is a really hard situation and doing that kind of unpicking. It's that kind of … that relief of sharing it with others, I guess. And not having to hold it all.*

Jasmine spoke about feeling defeated, both as a team leader and personally, when her tried and trusted strategies failed. Referring was her attempt to contain her own anxieties, those of the child's grandparents and of the team she was managing.

Jasmine p25: *I was thinking what have I … what have we done wrong? What are we not doing? And I guess it knocked our ah, myself and the team's confidence a little bit because we always kind of prided ourselves in being great with our SEN and our emotion coaching and it hadn't worked.*

Jasmine was also mourning a feeling of a damaged professional reputation as other children were being hurt by this boy and there were internal and external pressures to find a quick solution. It seemed she had internalised a sense of failure as she had not found a solution, and this seemed intolerable.

Jasmine p26: *And obviously from a nursery point of view, we had nursery complaints from other parents because children are going home hurt. And you, you're doing your best and telling your parents … you're telling all the parents that you're doing your best. And actually, yeah, you can feel really defeated. That actually everything that you've done … hasn't worked. And yeah, you feel … and then to be validated actually. No, you've done a really good job, that was really, really important.*

Jasmine felt the validation in the Consultation Group's acknowledgement of their good work was uplifting and motivating. Likewise, Kirsten felt sharing her burden helped her mental

health. Her experience of feeling understood by the Consultation Group, alongside being offered long-term support seemed cathartic.

Kirsten p15*: they're gonna work with him for a year, it was like, wow! Thank God (laughs). So, yeah, that's brilliant news. So, it depends on the outcome on how you feel afterwards.*

Kirsten felt the effect on her mental health was contingent on whether or not direct work was commissioned, which was echoed by the other participants.

The participants felt presenting to the Consultation Group had a positive effect on their mental health and they spoke about finding relief and a sense of peace in sharing their concerns with skilled professionals, likening it to restorative supervision.

Daisy p13: *it works as a sort of like a restorative supervision almost… like looking at. Okay, well, what has been done and what… could that potentially mean for that family and for those children and … yeah … no, no, it was, it was really …. it was really good*.

The Consultation Group was experienced as a place where the participants' own mental well-being was foregrounded and actively thought about, which had the effect of reducing the stress they were holding and bolstering their resilience.

Kirsten p20: *just the opportunity to be heard is something. And during that hearing… being heard … to be contained is really, really good. You know … to have your … to be listened to, to have your … worries and your concerns kind of acknowledged and yeah. Just that, it is just that opportunity to kind of ... it feels a bit like a supervision.*

Jasmine spoke of feeling supported, more confident and having renewed sense of empowerment that was extrapolated beyond this case into her work with her newly empowered team.

Jasmine p24: *So I think [the pilot project] allowed me to realize that actually, we were doing our job and that really supported my mental health and the fact that I had done all that I could.*

Daisy highlighted the importance of sharing risk and gathering the network around the child to think and mobilise.

Daisy p15: *I guess it is the getting everyone together. Yeah, it's hard to say because I'm not involved with the family any longer so raising concerns and then highlighting it to all professionals involved and … getting the supervision from child psychotherapists is really great.*

The number of clinicians in the Consultation Group varied widely, the participants reporting between four and ten professionals. While the participants appreciated the experience and diversity of the panel, this was mitigated by a reduced sense of intimacy if the panel felt too large and intimidating.

Kirsten p13: *Yeah, bit of trepidation, I'd say. Because it's all a bit like, you know, you're sitting there like sometimes there's there can be like eight people on the panel. Sometimes there's only four, but it's like, you know, it can be quite a bit like the Brady Bunch looking at the screen with all these faces!*

Daisy questioned the ethics around large numbers of professionals in the Consultation Group when they could arguably be better used elsewhere as direct support to stretched services.

Daisy p17: *Is that … is that the best use of resource in that sense? Having a panel that, you know … where you have several child psychologists or psychotherapists, educational psychologists and mental health professionals, midwives, health visitors. At a time when we just can't give women and families the time they need and deserve? Is that the best use of time?*

Daisy's frustration over the lack of provision in under-fives' services was amplified by what she felt was the extravagance of having so many professionals reflecting for two hours in consultation. This felt deeply uncomfortable and conflicting for her.

Daisy p17: *I really admire the work that is going on. Umm … but also its … it's sooo difficult for a service user to access child's psychotherapists, or any kind of CAMHS input. So, it sort of can feel like a real luxury and indulgence as professionals to sit and reflect and take a couple of hours …*

For Daisy, the significant effort and time referring required, having to work beyond the time limits of her midwife role and still not getting direct work or ongoing support for patient was a potential barrier to future referrals.

Daisy p10: *The reality is that we are just on our knees and we don't have the time commitments or the time available.*

iii- **Professional diversity**

Online working practices

On one hand, there was a tacit acceptance among participants that online work had become an inevitable part of their professional futures. This was somewhat balanced by an appreciation of the convenience it offered in eliminating travel and facilitating more diverse meetings.

Leyla p29: *the power of [the pilot project] is having that multidisciplinary team and having people from such wide backgrounds. And I do feel like virtual working has made that much easier across the board. Because you're sort of cutting down travel time and everyone's so busy that the more you can minimize time doing stuff like that, the better.*

While three participants preferred presenting to the Consultation Group in person, Leyla found online working preferable as it removed the need to meet face-to-face.

Leyla p13**:** *Aah… It can feel a bit spotlighty…. I find it nicer doing it virtually rather than in a room full of scary people.*

Kirsten, a proponent of face-to-face working, appreciated the convenience of online meetings, but lamented the loss of closeness and containment in-person teamwork provides, which was in line with the other participants.

Kirsten p42/43*: I don't know how, but yeah, I think anything where you get the opportunity to come face-to-face with people and chat about stuff, it's really … it's good. And I realize that now more than I did three or four years ago when it wasn't Covid. Because we didn't realize how much we needed it.*

Attitudes to males

While professional diversity was felt to be a strength of the pilot project, the place for males throughout this study felt difficult to grasp. For the most part, the importance of including fathers or having a gender diverse workforce was not actively considered. When males were discussed, they were sometimes experienced as a negative or complicating presence, rather than being valued. Kirsten felt professional habits of not actively including fathers during maternity had been prevalent in the past.

Kirsten p33: *To be fair… health visitors in the past and services generally have been, with regards to maternity, have been really poor at including dads.*

Kirsten spoke about the dangers of infant mental health professionals instilling or reinforcing the view that fathers are unimportant in the early years, even those who are part of a healthy relationship.

Kirsten p34: *I think if you … if you're telling someone that they're not important at regular intervals … then they're gonna start to feel that they're not important.*

Kirsten voiced concerns about fathers being excluded, actively and passively, and the ramifications on the father-child relationship.

Kirsten p34: *But if professionals don't see them as important, then that's quite significant, isn't it?*

Whether or not fathers were involved, uninvolved or excluded was unavoidably complicated by issues of domestic violence which threatened the safety of mothers and babies. Kirsten felt experience and being prepared were fundamental in recognising the signs of domestic violence.

Kirsten p37: *you have to have an ability to kind of … yeah … read the situation and … and know what domestic violence is. And understand, you know, read the case studies. Do the training, do the work.*

The professionals working at the frontline with mothers and babies are frequently dealing with the effects of domestic violence, which is highly likely to influence how and when they include fathers. While domestic violence was a central concern for referrers, it was not the primary reason for the referrals the participants made. Rather, past domestic violence formed a complex part of the broader context, specifically how adverse experiences affected the mother-child relationship in the present, both directly and indirectly.

It seemed there was little thought about gender diversity as important in makeup of the Consultation Group. Leyla, who has been both a referrer and a professional on Consultation Group panels, commented on the presence of males in the pilot project.

Leyla p34: *I'm not sure I've ever seen a man in [the pilot project] actually (laughs nervously). And so many of our roles are very female dominated and you know … thinking about early years professionals generally. It's a very White British middle-class female dominated world.*

Leyla began to consider the diversity of the panel in terms of race, class and gender balance and remembered an occasion when a male was present.

Leyla p35: *Oh! We have had someone from DadPad actually! He was at one of them, I think. And that was actually really nice to get a different perspective. That was really powerful. They brought a lot to that meeting.*

Leyla felt the inclusion of a male perspective provided a more balanced understanding and improved both the diversity of the panel and the quality of advice produced.

Leyla p35: *it just … it felt very different. I think that would be really positive if we're able to improve the diversity of the panel. To get those different perspectives.*

The participants' believed diversity was a fundamental strength of the Consultation Group. However professional diversity was the focus and gender diversity did not appear to be actively considered or to have been deemed significant.

Kirsten p33**:** *I think the climate is changing … definitely in health visiting … shame it's taking so long, but it's … it's happening, I think.*

Daisy had a different experience and spoke about the frustrating presence and practice of a male clinician in the Consultation Group that she had found invasive.

Daisy p21: *it was all women except the male on the panel, and it was really interesting how much he did the talking. And he'd never met this family … and I think there was a real gender imbalance going on in that he took the word and … ran with it, and … um I found that was … um … interesting.*

I wondered about the presence of males in under-fives' settings, an area that has traditionally been a female centred space. Daisy's response was as follows:

Daisy p22**:** *Female centred. I don't know. I think it's more … there's plenty of evidence and research out there to show that in any public speaking … or any kind of meeting room, that men get more speaking time or take more speaking time. And that was definitely the case. There was one male. He's never met the family, yet he was doing an awful lot of talking.*

Daisy cited empirical evidence of men habitually appropriating female space. This male clinician was singled out for not knowing the family, but this would have been true for most female members of the Consultation Group as well.

3. Outcomes from referring to the service

i- Bespoke training for professionals

The provision of bespoke training led to Jasmine's nursery team feeling recognised and contained in a time of acute distress when trying to support a little boy and his grandparents. Jasmine spoke warmly about how their bespoke training generated a sense of gratitude for a helping hand offered by a pilot project psychotherapist when the nursery team was struggling with feelings of self-doubt.

Jasmine p8/9: *So, she actually did some support for us. Just for our setting, about how his behaviour affected … the practitioners' practice … it wasn't their fault. It really uncovered … especially for less experienced practitioners, it allowed them to express how his behaviour made them feel, and then that uncovered how they dealt with his behaviour and that was really helpful.*

Jasmine credited the bespoke training as being fundamental to changing the team's attitude, as it helped them understand how the boy was processing his new life. The team appeared to have been feeling undermined and overwhelmed by the boy's behaviour and they had been experiencing feelings of anger that felt unsafe to voice openly. The training provided a safe space to collectively express their pent up and confused emotions to an outsider, reducing their fears of professional fallout.

Jasmine p2: *initially, he started and he seemed absolutely fine, well-mannered, well-behaved. We had no concerns, but as he became more safe, he knew that he was safe within the early years provision and with his grandparents. He then started to show signs of distress, dysregulation and just not really being able to process everything that'd been going on in his life previous to having somewhere safe to be. And that's what led us to making a referral.*

Jasmine said the team and grandparents had been initially confused and frustrated by the little boy's rejection of their collective attempts at helping him.

Jasmine p3**:** *He had obviously been fighting for so long and just remaining safe. He was found several times searching for food in dustbins on the street, and I think he just for so long had to be okay. And then when he almost didn't need to be okay anymore and he felt safe, that's when these behaviours and the trauma kind of came … seemed to be coming back to him.*

The training supported Jasmine's team to realise the child was not personally attacking them or the other children due to an inherent character flaw. They came to understand how his past trauma was affecting his ability to adapt to the new lifestyle he was being offered and that he now felt safe enough to express his anguish.

Jasmine p27/28: *He just couldn't cope with … his new lifestyle and … the love that he was receiving because he just never had it before.*

While all the participants found the experience of consultation to be cathartic and validating, success was more difficult to define if direct work had not been offered or had not been successfully put in place. When receiving direct work in the form of bespoke training alongside consultation, as in Jasmine's case, the experience of referring seemed truly transformative for the participants and their patients.

Jasmine outlined three aspects of success from the experience of consultation and receiving bespoke online training. Firstly, the improved understanding from the consultation enabled the team to better understand the boy's emotional state. The team then implemented the strategies they were taught to contain his anxiety and aggression and he began to show improvement.

Jasmine p28: *So, the success was the decrease in his behaviour and him able to… regulate his emotions.*

Secondly, there was success for the family as their situation improved substantially. This was due to the coordinated strategies put in place in the nursery and in the home that provided a sense of consistency for the boy.

Jasmine p29: *the success was that the family now live a happy, lovely life with a little boy who seems to be able to start… he's starting to uncover that trauma with the support that he really needed.*

And lastly, Jasmine's personal success came from a sense of growth from surviving the difficult situation, improving her understanding, and developing a competent team.

Jasmine p29: *I guess my success is that I have a team now who are empowered. If we have another child in that situation, we know exactly kind of … how we're gonna go about it. We've got those new strategies that we would start using, and we would hope that if we made a referral that we would obviously get the same support again. So, we know that we're kind of not on our own this time, which is how we felt at the beginning last time.*

Jasmine's experience of receiving both consultation and bespoke online training demonstrated the potential of this combined approach, in comparison to participants who only received consultation.

Jasmine p27*… that [training] really allowed our staff to realize that the behaviour wasn't necessarily aimed at … them and the other children.*

Jasmine felt supported by the consultation and bespoke training they received. The benefits of the training went beyond her newly empowered team as she shared her deeper understanding of theory and strategy with three other settings.

Jasmine p7/8: *Yeah, it's been really successful. So, I'm Behaviour Lead for not just for my setting but for the company and that's been really sort of … because I've been able to offer that support to the other settings within my team. So, it hasn't just helped that little boy, to be honest, it's helped improve the practice of lots of people that work for the whole company because we've been able to cascade the learning that we had in the first place.*

The combination of consultation and direct work led to an exponential improvement for the patient, family, inhouse team and nursery network, for which Jasmine felt both proud and grateful.

Jasmine p9*: I think if [the pilot project] could offer those kinds of services to other nurseries, it would be really, really helpful.*

ii- Managing expectations

lt is important to keep in mind that all the participants cited getting specialist direct work for families as their main reason for referral and when this did not happen, both referrers and patients felt disappointed and let down. While there was recognition of the positives of online consultation meetings for professionals with regard to convenience and efficiency, the participants unanimously felt that pre-recorded online training for patients was disappointing and frustrating. Kirsten speaks about the online support she was offered:

Kirsten p15: *the only recommendations were [pre-recorded] online things … like Solihull training for parents online and that kind of stuff. But no actual one-to-one support and I suppose I felt a little bit … let … disappointed because you know, I'm holding this child and I'm thinking, you know, if I could get someone else to come in and do something with them, which is good for them, that would be really great. But when they tell me they're just gonna give me [pre-recorded] online stuff that's a little bit like, deflating, I suppose.*

It seemed far less likely that participants would refer in future if only professional consultation or pre-recorded online training for patients will be offered. The process of referring raised both referrers' and patients` hopes for direct work or 'actual one-to-one support'.

Kirsten p22: *I was given stuff that was online to … to pass back to mum, when I took it back to mum, she was like, well whatever. She's like, really not fussed at all and she didn't feel that there was any … it wasn't worth her while at all.*

Unrealistic expectations for one-to-one treatment may have resulted from a lack of clarity in the referral information on the pilot project`s online information (Appendix 8). Consequently,

when only pre-recorded online parent training was recommended there was a sense of feeling let down and of having been offered a second-class treatment. The pre-recorded parent training had little perceived value to referrers and patients alike as they wanted direct, face-to-face contact with a professional. It appeared to feel invalidating, potentially eroding the cathartic experience of referrers receiving consultation, and this may create a barrier to future referrals.

Kirsten p24: *with anyone that's getting told just to do the [pre-recorded] online stuff, I think, it just doesn't … work for us.*

A further difficulty was that when direct work was offered, it was not always delivered. Leyla spoke about two instances of short-lived elation and relief at being offered face-to-face psychotherapeutic support, which was followed by disappointment and disillusionment when the recommended treatment did not take place.

Leyla p20: *Umm. I think for the [first] one I mentioned … getting access to the psychotherapy did feel like a really positive step, but then obviously it didn't go to plan. Another referral that I made … they allocated a trainee to go and work with the family, which again seemed like it could be a really positive thing. But then … that didn't seem to happen… or not in the way that I'd expected it to … I don't know. It all seemed to get a little bit messy and I didn't feel like anyone was really kept in the loop as to what was gonna be happening.*

Leyla felt responsible for putting her patient through the process, raising her hopes, and then letting her down after the direct work did not take place.

Leyla p25: *I kind of said, 'Oh yeah, you know, it's great. You know, we've been allocated this person, and they're gonna be able to come and see you every week' And it be really good. ' And then when it didn't happen, it felt like I'd let them down.*

The participants found it uncomfortable to criticise the pilot project as there was a strong sense of gratitude for being contained so effectively by the consultation experience and the knowledge that it was still a pilot project, not a commissioned service.

Kirsten p21: *in the presenting side of things, I don't … I think you know … it was it was perfect. I couldn't fault it really. It definitely made me feel heard, for sure.*

However, this sense of positivity about the consultation experience quickly diminished and turned to a sense of disappointment and grievance when direct work was not offered.

Daisy p6: *It felt like … a space to … for professionals to think together. But not so much a place to access intervention or support for the family.*

Follow-up

While Jasmine felt she and her team had a rich and encompassing experience of consultation and bespoke training for her nursery, she felt suddenly dropped once it had finished. She said there was no follow-up or checking in to find out if the support had been effective or if they needed additional advice.

Jasmine p30/31: *I guess once we got the outcomes … from [the pilot project's] perspective, ah … we didn't really have any "How's it going? Do you need any support?"*

This sense of abandonment after being well looked after had an unbalancing effect on Jasmine and left her feeling confused. However, she was ambivalent about directly voicing any criticism towards the pilot project, as were the other participants.

Jasmine p31/32: *I wonder if some settings wouldn't re-refer or wouldn't say, 'Hey guys, this isn't working … we need more help. ' Umm, so I wonder if like … a check in a few months later before the case was closed would be … would be helpful.*

Jasmine felt the pilot project had assumed the intervention had been successful and had not sought feedback before discharging.

Jasmine p32: *I'm guessing from my point of view, [the pilot project] don't know whether it works.*

There was a feeling of sadness about things not being tied up properly and being dropped by what had become an idealised mother figure.

Jasmine p33: *They helped a great deal for us, the most successful that we could have hoped for. However, you guys had no idea that we've been successful until I spoke to you.*

Jasmine linked me with the pilot project and used this opportunity to find closure by informing me that they had been successful.

iii- Involving family members in the consultation process

Daisy offered the pragmatic solution of using the considerable expertise of the Consultation Group as an effective therapeutic tool for some patients.

Daisy p18: *it would it be an idea to invite the person we're talking about to the group so that they're actually really a part of it much more? In fact, I think … just thinking it through now, I think I'd like to see that they were part of it and they actually were able to … listen and learn and ask questions from these people who are so skilled.*

Jasmine's experience of attending the Consultation Group with a grandparent demonstrates the potential effectiveness of Daisy's suggestion to include parents or carers, when appropriate.

Jasmine p11/12: *I think it was the first time that the grandparent had sat down and opened up about all of her concerns … to so many people. And I think it was the first time she ever felt heard. It was the first time anyone had ever acknowledged like, you're doing a great job and you're trying to do the best for this little boy, and let's get you some help … her whole attitude towards the services changed after that meeting.*

It seems the referrers may have viewed the pilot project as a panacea in a time of crisis. These unrealistic phantasies appear to have been compounded by the lack of clear information about the pilot project's remit. Leyla had experienced the frustration of not receiving promised support but had also been a professional on Consultation Group panels.

She was therefore able to provide a nuanced insider perspective of what could realistically be offered.

Leyla p27: *That can sometimes be frustrating … when you're hearing about this really, really complex situation and there isn't anything that can be done. There isn't always, you know, there isn't a magic wand. As a referrer, I think that must be really hard … to bring this really complex situation and then not really getting a concrete outcome or a next step.*

Chapter 5: Discussion

This chapter explores the superordinate and subordinate themes that have been outlined in the Findings chapter. In this chapter I link the salient key concepts from theory and research and reflect on my experience as a researcher interviewing participants.

1. Reasons for referring to the service

i- Referrers feeling overwhelmed

The data show that participants had a shared aim in referring: to get support because they felt unable to provide the care their patients needed. Moreover, the data show that referrers felt under significant pressure: chronic pressure from their large caseloads and acute pressure from particular complex cases. The combination of these pressures is likely to have led to a desire for concrete solutions (Emanuel, 2012) in the form of direct work, and a desire to pass on responsibility to the pilot project, rather than being able to hold the uncertainty (Bion, 1962/2019).

The referrers experienced different pressures depending on their profession and `direct work` had slightly different meanings for each participant. For example, Jasmine, a nursery manager, wanted specialist strategies and advice to continue supporting a four-year-old boy, his family and her team. Whereas Daisy, a midwife, needed to pass her patient onto another professional because her work remit only allows her to stay involved for four to six weeks postnatally. While Daisy appreciated the thoughtfulness and professionalism of the Consultation Group, her aim was continuing direct work from another professional, not consultation.

The data indicate that the time restraints midwives face result in the pilot project being less compatible than for professions who are able to continue working with the young person and their family for a longer time, such as nursery teachers.

A potential solution to this misalignment between the pilot project and midwifery is more efficient joint working between midwifery and health visiting services, as outlined in the care

continuity document (Public Health England, 2021). This document provides information and guidance about how midwives and health visitors can communicate about vulnerable or high risk patients. Health visitors would then be forewarned and well-placed to provide early intervention or to refer to the pilot project, relieving the pressure on the midwives to work beyond their time remits.

ii- Significant concerns about adverse parent-child relationships

The participants referred cases where abusive family relationships and unresolved intergenerational transmission of trauma had led to the parent-child relationship becoming compromised. In some cases, negative attributions from mothers to their children were of concern; when these are extreme they can constitute a form of emotional abuse. In Kirsten`s referral, the mother was emotionally abusive, but due to their good working relationship, they were able to identify the risk of the mother potentially becoming physically abusive towards her daughter.

Murray (2014) writes that parenting does not exist in a vacuum and that the number and severity of background difficulties parents have to navigate affects their capacity to provide consistent sensitive care. Lieberman et al. (2014) maintain that the `ghosts in the nursery` represent the unhelpful repetition of the past in the present which takes the form of punitive or neglectful practices. In essence, the parent fails to fully comprehend the meaning of their child`s communications of need and may ignore their projections and communications or misconstrue them as proof of the child`s inherent badness. Lieberman (1999) writes that due to the emotional complexity of these moments, the parent`s visceral reaction displaces their baby`s developmental needs. The parent may then respond with anger, rejecting the child`s need and adding the weight of their own unprocessed emotion. As the parent is unable to contain the child`s experiences, metabolise them and pass them back in a meaningful way, the child is marooned in a state of meaningless fear, or nameless dread (Bion, 1967/2018).

Lieberman (1999) believes that negative maternal attributions can start at the child`s birth, or even before. These early negative attributions can have a significant effect on maternal behaviour and impact on the child.

> *Gradually, the maternal attributions come to shape the child`s sense of who he is. The children come to see themselves in the ways their mother`s see them, and they behave in the ways their mothers expect them to behave*.
> (Lieberman,1999, pp. 741).

Lieberman (1999) adds that these mothers often attribute to their sons the same violent impulses acted out on them by the males in their lives, thereby making them the unwitting receptacles of unmetabolized phantasies and experiences that are projected into them (Williams,1997).

In both Leyla's and Daisy's referrals, the mothers` rage towards the fathers was being directed towards their young sons. It seems both these mothers saw the abusive part of the fathers in their sons and treated them as if they were abusers themselves, rather than little boys. These boys had begun to act out in projective identification (Klein,1946), reflecting the hated and feared version of the father. In doing so, these boys had become identified with the aggressor (A. Freud, 1993) and had become the abuser as a defence against being the abused, thus perpetuating the intergenerational transmission of trauma.

In these instances, the participants felt under pressure to find a solution in the form of ongoing specialist work for their patients to repair the parent-child relationship, to keep the children safe from harm and also to relieve themselves from the risk and complexity they were holding.

As a male researcher, I became acutely aware of being male and the significant weight of being associated with and being experienced as a particular type of male – the bad, dangerous and subversive father. I recognised my acute discomfort and desire to actively distance myself from the stigma of this particular type of maleness and my powerlessness to do as a researcher, but also as a therapist and student.

iii- Secondary trauma

From Bion's (1962/2019) work it is understood that when parents, or under-fives workers in this instance, do not feel contained they are less able to take in, metabolise and return their child`s or patient`s projections in a considered manner. Shonkoff and Phillips (2000) and Berlin and colleagues (1998) maintain that the emotional availability of under-fives workers, and their sustainability and ability to develop personal relationships with families rely on the quality of their training and work experience. However, a Parent-Infant Foundation report (2021) found many NHS mental health professionals feel they lack the skills and confidence to deliver parent-infant work effectively. The data from my research support this and it appears that the participants believed they were ill-prepared to cope and had consciously or unconsciously hoped the pilot project would assume responsibility through referring some of their more complex cases and patients.

This pressure led to a need for quickness and action in the participants` thinking, which clashed with the slower and more thoughtful consultative approach from the pilot project. At times it appears that the participants may have been left with a more nuanced and painful understanding of problems they believed they still lacked the skill or time to solve. This may have further undermined the participants' confidence, adding to their burdens rather than relieving them and potentially increasing the likelihood of them experiencing professional burnout (Maslach, 2001). In these instances, the consultation may have been experienced as a double-edged sword by the participants.

2. Experience of the service

i- The referral process

The data indicate that participants were frustrated by the lack of information and feedback from the pilot project regarding expected waiting times once referrals were made, leaving them holding the uncertainty (Bion, 1962/2019). It appears that having to wait for an

unknown period of time was experienced as persecutory, particularly as the participants had to contain the collective hopes and anxieties felt by their patients and themselves. Daisy experienced the referral process as overly complicated and time-consuming. However, it is likely the effort required would have seemed worthwhile if her patient had been offered ongoing parent-infant psychotherapy she desired.

Significantly, it was not well understood by the referrers that the pilot project was being run by two child psychotherapists, who continued to work in their normal roles. At that time, they had minimal funding and were initially without administrative support. Additionally, the Consultation Group is staffed by professionals from allied services who voluntarily provided their expertise and are not on the pilot project`s payroll. I believe the misunderstanding about the capacity of the pilot project to liaise promptly and provide direct work led to unrealistic expectations from referrers, often desperate for concrete solutions – this made it difficult for them to hold in mind the pilot project`s limitations.

ii- The consultation

The participants' experience of the Consultation Group and the consultation-based way of working clearly provided an extremely rich, validating, and cathartic encounter. The participants reported feeling immense relief at being able to speak openly about patients where things felt stuck and valued the collective expert advice they received. The consultation provided an effective containing function and supported the referrers to feel part of a cohesive team that shared the risk, which they valued. This was particularly true if developing a deeper understanding was a significant reason for referring, Leyla being the sole example. However, for the remaining three participants, obtaining direct work was the aim, and the consultation experience lost its nutritive impact when it was not followed up by what Daisy called 'meaningful intervention'. It appears the participants felt suddenly dropped after the Consultation Group had developed a clearer understanding of the situation, but still did not offer ongoing support. The previously valued consultation aspect of the service then became subject to denigration.

While the pilot project's focus is on consultation, the data show this was not properly taken in and processed by the participants, a likely consequence of the pressures they were under. For instance, Daisy spoke of the Consultation Group being a space for professionals to think together, but not a place to access meaningful intervention or support. While this is an accurate description of the consultation process, it was expressed in frustration and disappointment by Daisy, showing her confusion about the primary function of the service.

iii- Professional diversity

The participants praised the diversity of the Consultation Group as a fundamental strength of the pilot project, as it facilitates a wide range of early years professionals to come together from across the county. However, the participants also questioned having as many as ten professionals discussing a case for two-hours. It appeared the benefit of a diverse panel was lost when it was too large, as it was then experienced as intimidating and potentially overwhelming. Daisy spoke about her admiration for the pilot project's work but said the large number professionals and the time taken in consultation made it feel like a 'luxury' and an 'indulgence', particularly when families struggle to access parent-child psychotherapy in the county.

There is a strong ethical argument for gender diversity in parent-infant and under-fives' services when striving towards best practice. Data from the GenderEYE project (2020) show that despite the Department of Early Years Education (DfEE) 1998 target to increase male representation in the UK early years workforce to 6% by 2004, almost 20 years later the number remains stubbornly between 2% and 3%. Significantly, this statistic was reflected in the gender imbalance in the staff making up the Consultation Group. If we as a profession are invested in true diversity, it would seem including fathers, where appropriate, and remedying the underrepresentation of male professionals in under-fives settings should be enthusiastically pursued to improve the service.

As under-fives work is not a traditional route for males, a concerted effort will be required to ensure clear career pathways are created for males to be involved from grassroots levels, as has been necessary to address systemic sexism and the disproportionately small numbers of females in science, technology, engineering, and mathematics (STEM) occupations. I believe the pilot project and the under-fives community could learn from the insightful work done by for instance, Glass and Minnotte (2010) and the GenderEYE project (2020) to gain the benefits from a more equitable and truly gender representative workforce that accurately reflects the diverse community it serves.

iv- Online training

Two types of online training were provided: pre-recorded training programmes for parents and live interactive training for staff. The data showed that pre-recorded material was not experienced as the effective method of training the pilot project had envisaged, it was experienced as a second-rate alternative by both parents and participants. Parents felt let down and unimportant when they were not offered direct work and both Leyla and Kirsten expressed serious misgivings about parents completing the online programme. This left the participants in a difficult position – they had to continue holding the risk for the case, the containment of the parent`s frustration and their own anxiety after the input from the pilot project had ended but had not met their aim for referring. Kirsten said that she felt that whether the referral was successful or not was directly related to the type of support that was offered. It is highly likely that the expectations of receiving direct work contributed to online work being considered a second-class option.

In contrast, the live online training Jasmine and her team received proved extremely effective and was highly valued. It seems the lesser experience of having training online was mitigated when it was led by a live practitioner who could interact with the learners, but in this example, the learners were staff members, not parents. This live online training allowed

the nursery staff to actively use the trainer as a container, whereas watching a pre-recorded video appeared to feel isolating and somewhat persecutory for parents.

v- Attitudes to males

While professional diversity was viewed as a fundamental strength of the pilot project, gender diversity with regard to the place of fathers and male clinicians appeared not to be actively considered. It may be that involving fathers creates complications for a number of reasons, including logistical issues, as highlighted by Barrows (1999b), Jones (2006; 2019) and Salomonsson and colleagues (2019).

Nonetheless, there is contemporary recognition of the importance of diversity and the benefits of a workforce that accurately reflects and represents its service users to ensure a more inclusive experience - where service users are supported by people who 'look like them'. Kirsten, Leyla and Jasmine were in favour of a more representative and gender diverse work force and believed fathers and male under-fives professionals were underrepresented. However, Daisy felt that the one male professional in her Consultation Group constituted what she called a 'gender imbalance' and it seemed she experienced him as appropriating female time and space. Daisy singled him out for speaking about the family, but not knowing them. This would have been true for most female Consultation Group members too and reflected Daisy`s bias.

I wondered if Daisy was caught up in an unconscious re-enactment (Britton, 1981; Emanuel, 2002) of her patient's abusive domestic situation. It seemed the anger and frustration felt by Daisy's patient may have been projected into her and was then being projected into this male member of the team who Daisy appeared to experience as potentially abusive and dangerous, but certainly unwelcome (Emanuel, 2002). Moreover, during the interview I was aware of feeling decidedly uncomfortable when Daisy was describing this 'gender imbalance'. I was mindful of Holmes' (2014) view that countertransference is an effective research tool as I believe I had become identified with a sense of unwelcome maleness that

unfairly appropriated female space, compounding the gender imbalance and arousing anger in Daisy.

It is unclear if the working culture in under-fives' services and the pilot project was re-enacting a broader cultural bias or if there is a systemic discomfort with males working in what Leyla described as the overwhelming middle-class female dominated profession of infant mental health. However, it appears there is a risk of the prevailing gender biases of the past being repeated consciously and unconsciously in early years institutions, running the risk of keeping them systemically entrenched in professional practice, unless they are openly and honestly addressed (Glass & Minnotte, 2010; GenderEYE, 2020).

During the course of my research, what initially felt confusing but ultimately dismaying, was the resistance I faced from my research supervisor about highlighting the gender imbalance in under-fives` services, which was discouraged. My research supervisor felt that drawing attention to Daisy`s grievance about having a single male in the Consultation Group and that having so few males in under-fives services was unhelpful as it did not constitute a gender imbalance and therefore no change was necessary. This difference of opinion let me in a conflicted position. The IPA format requires the researcher to honestly interpret their subjective experience of the data, but I also needed my research supervisor`s support and guidance to complete my research. In the research process, I repeatedly had the experience that my interpretation of the data was viewed as an unwarranted attack on the under-fives community and the pilot project. I frequently took this dilemma to my own analysis to consider what I was bringing to the research in terms of my own biases and how I was potentially being experienced by my supervisor.

This challenging experience led me to research Bion`s work on projective processes, unconscious defences, and his concept of catastrophic change in an effort to make sense of the situation. Glover (2009) maintains that Bion believes thinking, and creative processes, necessitate the dismantling of existing views to allow the space for new ideas to form. Pozzi-

Monzo, Lee and Likierman (2012) share Bion`s view and write that creative thought can be perceived as a minor psychic challenge to the containing structure, sometimes dissolving it before it can be reformed, which may be experienced as a minor psychic catastrophe. Glover (2009) likens this dissolution of entrenched thinking to the paranoid-schizoid position, and the reforming of a reconsidered and evolved set of views as a move towards the depressive position.

While ingrained ways of thinking and mental structures provide containment and solace, they also limit new ideas and creative thought. Bion (1962/2019) suggests that the alternative is to endeavour to tolerate challenges, with a view to developing an alternative and more nuanced understanding of the world. Glover (2009) writes that Bion maintains that the ability to tolerate a painful process depends on the individuals capacity to bear doubt, to hold uncertainty – and that this ability ultimately determines the potential for growth in the individual. Joan and Neville Symington (1996) write that Bion`s attitude to truth is that beliefs or perceived facts should be tested against phenomenological experience to verify or discredit them.

On reflection, I realise that what I had construed as an important truth emerging from my research about the need to improve gender diversity, appeared to be experienced as something fundamentally destabilising, exposing and potentially catastrophic by my research supervisor. I believe my supervisor felt I was unfairly disparaging the under-fives community by highlighting the longstanding lack of male clinicians and the negative view of males that Daisy had raised. In essence, I think I was experienced as a harbinger of unwanted change to the status quo of the under-fives community. In turn, I felt my interpretation of the data was being misunderstood and then disregarded, leading to my feelings of deep frustration, powerlessness and of potential catastrophe for my research project. I believe this limited both my and my supervisors ability to reflect on how the processes of mutual projection and projective identification (Klein,1946; Bion (1962/2019) were contributing to an already febrile situation.

3. Outcomes from referring to the service

i- Bespoke training for professionals

The bespoke online training Jasmine and her nursery team received was a significant success as they were able to use the thinking mind of the child psychotherapist who led the training. The nursery team had felt overwhelmed, isolated and confused beforehand and they had projected their feelings of anger and inadequacy into the little boy, who was acting aggressively. These projected feelings had led to the team becoming afraid of him and disliking him, through the processes of projection and re-introjection (Klein, 1946). Jasmine felt the staff had avoided working with him, leaving the responsibility to her and her male colleague, who had formed a 'work couple' (Bion, 1961). The child psychotherapist conducting the training helped the team develop their understanding of how double deprivation (Henry, 1974) manifests and the internal struggles this little boy was having in accepting care and support, which they had felt as rejection. As the training was led by an external organisation, the nursery workers felt more confident to speak freely about their fear, anger, and dislike for the little boy. Once they understood that his behaviour was not a personal attack against them, and that he was struggling with his past traumas, they felt genuine empathy and warmth for him, and he responded positively.

An unexpected success was that Jasmine, in her dual role as the Behavioural Specialist in the company she works for, has been able to pass on her knowledge to the four other nurseries she oversees. I feel this example supports Wittenberg's (2008) view that parents, and in this case nursery schoolteachers, need a suitable outlet to consider the negative ramifications their own infantile and destructive feelings may be causing in the parent/carer-infant relationship. This interactive training provided a place to speak openly about their angry feelings, which upskilled the team and also bolstered their confidence. This supported their mental health and better insulated them from the effects of secondary trauma (Figley, 1995) and professional burnout (Freudenberger, 1977).

Jasmine and her team's experience of receiving bespoke training, albeit online, was effective as it provided a form of direct help she and her team needed. While this was a success, it raises the question of whose responsibility it is to provide training to early years professionals. It seems there are both systemic and organisational processes for under-fives workers seeking support from under-fives services that may lead to unconscious re-enactment that requires in-depth consideration.

Firstly, regarding systemic and organisational issues, if many referrers work for profit based non-NHS services or charities with less trained or experienced staff, it may benefit these organisations if responsibility for training could be passed on to external services, for example, the pilot project's consultation service. Employees of these organisations may come under direct or indirect pressure from managers to outsource 'difficult cases' to another provider. This could lead to the denigration of 'just consultation' and potentially to a misunderstanding of the purpose of the pilot project's primary aim of providing consultation to better equip early years professionals to hold complex cases, rather than providing ongoing work.

Secondly, professionals are more likely to be pulled into re-enacting family dynamics or operating at primitive unconscious levels (Britton; 1981; Emanual, 2002), when they are isolated, overwhelmed, or subject to significant secondary trauma (Figley, 1995). One consequence can be the impulse to both idealise and denigrate. It is part of the work of a consultation service to manage and address these dynamics - to help participants enter into a 'working group' state of mind rather than a gang or fight/flight or dependency state of mind (Bion, 1961). In essence, to support participants to be active agents in their working roles, rather than creating an unhealthy dependency on the consultants or consultation service (Wittenberg, 2008).

ii- Managing expectations

There were two fundamentally different perceptions about the actual service the pilot project offers. The pilot project seeing their role as primarily consultative while the referrers were mainly seeking to pass over responsibility for their most troubling patients through direct work - to get away from unbearable feelings of helplessness (Emanuel, 2012).

It appears the stress the participants' experienced led them to a paranoid-schizoid mind-set, which caused a split between an idealised mother-figure who listened, contained, and validated (consultation) and a denigrated mother-figure who withheld vital resources (direct work). Additionally, the direct work that was offered could not always be delivered as the allocated staff were sometimes unable to undertake the promised therapy. The participants reported receiving no updated information from the pilot project to explain the situation. This resulted in them holding both their own and their patients' disappointments and frustrations for raising their hopes and not delivering on the promises made. This left the participants holding an anger towards the pilot project that they had been unable to openly express as no feedback had been sought.

The pilot project may have initially been viewed as a panacea, an idealised mother, who could magically solve complex issues, or at least relieve the referrers of their intolerable burdens by taking the responsibility from them. This seems to have led to a situation where the participants had unrealistic phantasies of what could be offered and that the pilot project was unconsciously experienced as cruel mother spitefully withholding life-giving milk (direct support), perhaps only giving it to other 'siblings` (referrers) in phantasy. It appears that not getting direct help led to the rich and nutritive consultation experience curdling in the minds of the participants, leading to a sense of grievance and complaint about the ethical use of extremely scarce resources. This paranoid-schizoid thinking may have led to unconscious fears that the pilot project may become a retaliating breast that nurtures, but also deprives or attacks when it is criticised (Klein, 1946).

Gurion (2008) makes the salient point that therapists must resist substituting thoughtfulness with action in their work with distressed parents and infants. As Leyla said, 'there is no magic

wand' to solve all problems. It will never be possible to provide direct help, such as ongoing parent-infant psychotherapy, to all patients who are referred. It is therefore important that the pilot project continues to focus on the consultation model to bolster the referrers` ability to think and to hold the uncertainty, rather than aiming to pass on responsibility to the pilot project in an attempt to defend against psychic pain (Bion, 1962/2019).

In addition, it is worth considering that the pre-recorded parenting programme that was often recommended to parents may have been the pilot project's unconscious defence to mitigate against intolerable feelings of having insufficient capacity to provide direct and ongoing parent-infant psychotherapy to all the patients who needed it.

iii- The importance of ending well

Jasmine felt unbalanced by the abrupt ending of the involvement of the pilot project after the training finished - there was a sense of being dropped prematurely and not having their hard-won success recognised. Jasmine added that the pilot project had no idea if the intervention had been successful or not, as no feedback had been sought. I believe Jasmine had positioned me as a proxy, standing for the pilot project, so she could find closure in telling me of their successful outcome, and also to politely admonish the pilot project for not seeking feedback.

Nonetheless, the overall experience of bespoke training was remarkably positive and it proved effective for Jasmine, her team, the child and the family. This example demonstrates how when the nurturing energy of consultation and the pragmatic energy of direct work are balanced and supportive of each other, outstanding results can be obtained.

iv- Involving family members in the consultation process

The idea of using the Consultation Group as a therapeutic tool for patients was suggested by Daisy and championed by Jasmine, who described the experience of presenting to the Consultation Group alongside the carer of the little boy as cathartic, helpful and ultimately, very effective.

Jasmine benefitted from the inclusion of the carer in the consultation process for at least two reasons. Firstly, the carer had personal experience of access to a range knowledgeable and skilful early years professionals. Secondly, the Consultation Group became the authority figure, relieving Jasmine of her emotional and professional burden of potentially having to deliver uncomfortable information to the carer. The data show that involving the family helped Jasmine to feel supported while she was supporting the carer - to provide concentric containment.

In contrast, when Daisy reflected on not being offered direct work, she became frustrated, and this missed opportunity was experienced as a bitter loss. Daisy believed that if her patient had been offered access to the Consultation Group, [her patient] could have engaged and learned from these skilled professionals. Daisy's frustration was compounded by having to work beyond her time remit, and in her personal time, to attend the Consultation Group. This led to her perceiving the consultation process as overly complex, wasteful, and indulgent. It seems the stress Daisy was under reduced her ability to hold in mind the safeguarding concerns that would have made dual consultation for her referral inappropriate.

While involving the carer in Jasmine's case undoubtedly proved effective, the pilot project manager informed me that this is not usual practice – the Consultation Group`s function being to provide a thinking space for the network around the child and family. In fact, this was the only time a parent or carer has joined a consultation in the pilot project's history. On reflection, this creative use of the Consultation Group offers an opportunity to provide 'therapeutic consultation' to parents in cases where the threshold for direct work remains unmet. The parents' involvement in the consultation process, when appropriate, could make better use of scare parent-infant resources and provide better support for the under-fives workers referring to the pilot project.

Chapter 6: Conclusion

1. Summary

This research found that the participants referred to the pilot project when they felt overwhelmed by the complexity of the case and wanted specialist support. Moreover, the data indicated that in most cases referrals were made with the intention of securing direct work and passing responsibility for the patient onto the pilot project.

This research determined that the participants experienced the pilot project as a valuable resource and that they found the process of consultation cathartic, containing, and validating. However, there was a disparity in the pilot project's understanding of itself as a primarily consultation-based service and the participants' belief that direct and potentially long-term work would be offered to their patients after referral. When the threshold for direct work remained unmet, the referrers reported feeling deflated and frustrated as they were left with the situation they had been unable to resolve before referral. This left the participants feeling conflicted about the use of scare parent-infant mental health resources in the Consultation Group.

The data showed that clear communication about the pilot project`s primarily consultative role and the threshold for direct work is needed by referrers to prevent unnecessary confusion and to manage expectations for future referrals.

2. Strengths and limitations of the research

The primary strength of this study is that it provides unique data and analysis about the experience of referrers using this pilot project, therefore providing an opportunity to inform the development of the now funded service.

This study has a small sample, which reduces generalisability and can be viewed as a limitation. However, IPA values using small samples to obtain rich data that is examined at greater depth, over a shallower and more descriptive analysis of a larger number of

participants. This rich data allows for a more profound understanding of the experiences of the participants who used this under-fives service.

The participants in the study were provided to me by the Clinical Lead of the pilot project, who will have had a working relationship with all of them. It is possible that due to unconscious bias she might only have put forward participants who had positive experiences with the pilot project as a defence against negative feedback.

On reflection, I feel the project would have benefitted from having a male participant as this would have produced a more balanced study. However, the absence of males has raised important questions about how the sons of abusive fathers are potentially perceived by mothers, the place of fathers in clinical work and the lack of male clinicians in the under-fives workforce.

3. Reflexivity

In qualitative research it is understood that personal biases cannot be completely removed and that this influences how the researcher collects and analyses their data. I therefore endeavoured to remain mindful that my belief in the effectiveness of early intervention to reduce suffering for children and parents could bias how I carried out the interviews and my analysis of the data.

I was aware of the power imbalance between researcher and participant during the interviews. To mitigate this, I revisited the information sheet and consent form with participants before starting the interviews, reminding them of their right to stop at any time without needing to provide a reason. This appeared reassuring for the participants as they were reminded of my responsibilities to them and the educational institutions supporting my research and also of the power that they possessed as participants.

I endeavoured to create a positive rapport with the participants and endeavoured to put them at ease, while not becoming overfamiliar and potentially leading them with my use of verbal and non-verbal communications. Due to the Covid19 protocols in place at the time, the

interviews had to be done online. I believe that some nuance was lost by being unable to conduct the interviews in person.

During the analysis of the data, I continually thought about what I was bringing into the research in my attempt to make sense of the individual participants' views. I recognised my satisfaction that the participants had found the pilot project to be valuable and useful, but also my surprise at the strength of feeling behind the criticism directed at the Consultation Group, as this was also the most praised aspect of the work.

I realised I was concerned about being the bearer of negative feedback and the impact it may have on my relationships with the leaders of the pilot project, as we are part of a small psychotherapeutic community in the county.

I found being a male carrying out research challenging at times as the absence of male clinicians and fathers appeared to be unconsidered, as males were largely missing from the pilot project. This suggested fathers and male clinicians were not a significant issue for the pilot project and the wider under-fives workforce, which reflected the GenderEye (2020) findings regarding the perpetual underrepresentation of males. I found the absence of thought and recognition about the lack of gender diversity uncomfortable and frustrating, and sometimes rather jarring. However, it was clear that the majority of the participants valued gender diversity and a more inclusive approach and wanted the Consultation Group to be representative of the people who are involved as parents and employees. Importantly, Kirsten voiced her concerns about professional habits of not actively including fathers during maternity being prevalent in the past. In her experience, fathers had routinely been excluded and she was troubled about the potential negative ramifications on the father-child relationship. In addition, Leyla felt that when a man had been involved in the Consultation Group, it had enriched the meeting. The data showed that three of the participants were in favour of the pilot project improving gender diversity in the future when it became a commissioned service.

However, my research supervisor`s view was that the gender imbalance in the pilot and wider under-fives community was not problematic, did not to be remedied, and therefore deserved little discussion and interpretation. This placed me in a precarious situation as I needed her ongoing support, but I also needed to honestly interpret my subjective understanding of the data. I came to believe that my supervisor's resistance to my speaking about the gender imbalance and negative attitude about males in the data was a defence against what she perceived as an attack against under-fives status quo and the pilot project. I felt destabilised by what felt like a lack of power on my part, but also an ethical responsibility to analyse the data honestly. This was an extremely difficult time and I lent heavily on my own analysis, and Rubin`s (2023) thoughts and writing, to inform my thinking about the ethical responsibility to analyse data in an unbiased a manner as possible to create authentic, engaging and high-quality work.

On reflection, I believe I analysed the data honestly, fairly and with integrity so it could provide accurate and helpful insights to be utilised by the pilot project to develop the services they provide. I feel that this research from a male perspective is unusual and could be helpful beyond highlighting the issue of the underrepresentation of males in under-fives services.

4. Recommendations for practice

Firstly, there is a need for clear information to be communicated by the pilot project about the services it provides and the expected waiting times once referrals have been made. Having accurate and clear information will mitigate unrealistic expectations and ensure referrers have a sound understanding of the pilot project`s thresholds for both direct work and consultation.

Secondly, there is an opportunity for the pilot project to rethink the current structure of the consultation process. The participants reported feeling that the Consultation Groups were sometimes too large – this could feel both intimidating and wasteful. In the future,

professionals who might otherwise have been on a consultation panel could be relocated to support the referrer in the final `understandings meeting` with the parent instead. This would provide parents valuable access to skilled infant mental health professionals and an experience of being seen and listened to. This could mitigate the feeling of loss and disappointment of not being offered ongoing work and could be therapeutic and containing in its own right.

Thirdly, the research highlighted that the timescales midwives work to are currently out of synchronisation with the length of the pilot project`s referral process. However, improved care continuity between midwifery and health visiting, as outlined in the Care Continuity document (Public Health England, 2021), may provide an elegant solution to this problem. The Care Continuity document shows how effective collaboration between midwives and health visitors can ensure that vulnerable children and families are held in mind, which prevents them from becoming lost in the bureaucracy when moving between these two services. This improved joint working could significantly reduce the pressure on midwives to refer to the pilot project as their concerns about a family will be communicated to their health visitor colleagues who will have more time to properly investigate the situation.

Fourthly, the pilot project would benefit from actively considering how it approaches gender diversity to ensure a more representative and inclusive workforce that accurately reflects the changing nature of families it will support in the future - nuclear families, single-parent families, extended families and same-sex couples.

Lastly, due to the division of services between under-fives services and CAMHS, there is a potential issue about which service to refer to when a child is nearing their fifth birthday. Children who are deemed too old to be accepted by the under-fives service after a certain age may have to wait until their fifth birthday before beginning the referral process to CAMHS. This division into separate services might inadvertently create a different kind of ‘baby blind spot’ (Reed & Parish, 2021), meaning a lengthy period of inaction at an age

when research clearly advocates for early intervention. However, this division of services also provides an opportunity for better joint working between the pilot project and CAMHS teams, as demonstrated by the care continuity initiative (Public Health England, 2021). This improved communication may lead to vulnerable families being recognised and then referred to CAMHS to receive early intervention before the issue becomes entrenched.

5. Future research

Firstly, this research raises an important question regarding the young sons of mothers who have been the victims of domestic violence. I believe research into the outcomes for sons who are unconsciously projected into by their mothers, who have suffered domestic violence, could prove valuable in better understanding the intergenerational transmission of trauma that can manifest variously in both misogyny and misandry. We would benefit in understanding whether these boys come to embody their mothers' projections and become the misogynists they are believed to be in projective identification – thus becoming part of an uninterrupted and destructive cycle.

Secondly, it would be helpful if future research could focus on exploring parents` experience of using the pilot project to gain an insider perspective and learn more about their views on the effectiveness of the services offered.

References

Anna Freud Centre (2023). *Finding the right support for you and your family.* https://www.annafreud.org/clinical-support-and-services/finding-the-right-support-for-you-and-your-family/

Association of Infant Mental Health. (2023). *Hubs*. https://aimh.uk/hubs/

Aveyard, H. (2019). *Doing a literature review in health and social care. A practical guide* (4th ed.). Open University Press.

Balbernie, R. (1998). *A Strategy for Early Intervention and Prevention*. Winston Churchill Memorial Trust. https://www.churchillfellowship.org/ideas-experts/fellows-directory/robin-balbernie/

Balbernie, R. (2001). Circuits and Circumstances: The Neurobiological Consequences of Early Relationship Experiences and How They Shape Later Behaviour. *Journal of Child Psychotherapy*, *27*(3), 237–255.

Barrows, P. (1999a). Brief work with under-fives: A psychoanalytic approach. *Clinical Child Psychology and Psychiatry*, *4*(2), 187–199. https://doi.org/10.1177/1359104599004002005

Barrows, P. (1999b). Fathers in parent–infant psychotherapy. *Infant Mental Health Journal*, *20*(3), 333–345. https://doi.org/10.1002/(SICI)1097-0355(199923)20:3<333::AID-IMHJ9>3.0.CO;2-M

Barrows, P. (2003). Change in Parent — Infant Psychotherapy. *Journal of Child Psychotherapy*, *29*(3), 283–300.

Barrows, P. (2004). Fathers and families: Locating the ghost in the nursery. *Infant Mental Health Journal*, *25*(5), 408–423. https://doi.org/10.1002/imhj.20016

Bennett, C. E. and Christian, C. W. (2023). How Should Clinicians and Students Cope With Secondary Trauma When Caring for Children Traumatized by Abuse or Neglect? *AMA Journal of Ethics*, *25*(2), E109–E115. https://doi.org/10.1001/amajethics.2023.109

Berlin, L. J., O'Neal, C. and Brooks-Gunn, J. (1998). What Makes Early Intervention Programs Work? The Program, Its Participants, and Their Interaction. *Zero to Three*, *18*(4), 4–15.

Bick, E. (1964). Notes on Infant Observation in Psycho-Analytic Training. *International Journal of Psycho-Analysis*, *45*, 558–566.

Bick, E. (1968). The Experience of the Skin in Early Object-Relations. *International Journal of Psycho-Analysis*, *49*, 484–486.

Bion, W.R. (1961). *Experiences in Groups And Other Papers*. Tavistock.

Bion, W.R. (2018). *Second Thoughts : Selected Papers on Psycho-Analysis*. Routledge. (Original work published 1967).

Bion, W.R. (2019). *Learning from Experience.* Routledge. (Original work published 1962).

Blake, P. (2008). *Child and Adolescent Psychotherapy*. Karnac.

Bowlby, R. (2007). Babies and toddlers in non-parental daycare can avoid stress and anxiety if they develop a lasting secondary attachment bond with one carer who is consistently accessible to them. *Attachment & Human Development*, *9*(4), 307–319. https://doi.org/10.1080/14616730701711516

Braun, V. and Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*(2), 77–101. https://doi.org/10.1191/1478088706qp063oa

Brennan, M. (2014). Perezhivanie: what have we missed about infant care? *Contemporary Issues in Early Childhood*, *15*(3), 284–292. https://doi.org/10.2304/ciec.2014.15.3.284

Briggs, A. (2002). *Surviving Space : Papers on Infant Observation*. Routledge.

Britton, R. (1981). Re-enactment as an unwitting professional response to family dynamics In S. Box, B. Copley, J. Magagna and E. Moustaki (Eds.) *Psychotherapy with Families: An Analytic Approach* (pp. 48-58). Routledge & Kegan Paul.

Britton, R. (1989). The missing link: parental sexuality in the Oedipus complex In Britton, R., O'Shaughnessy, E. and Feldman, M. (Eds.) *The Oedipus Complex Today: Clinical Implications* (pp. 83-101). Routledge.

Britton, R. S. (1998). *Belief and imagination. Explorations in psychoanalysis*. Routledge.

Brown, J. (2006). Reflexivity in the Research Process: Psychoanalytic Observations. *International Journal of Social Research Methodology: Theory & Practice*, *9*(3), 181–197.

Cross-Party Manifesto. (2013). *The 1001 Critical Days: The importance of the Conception to Age Two period.* https://www.nspcc.org.uk/globalassets/documents/news/critical-days-manifesto.pdf

Cudmore, L. (2007). "It wasn't meant to happen like this": the complexity of mourning expectations In E. Pozzi-Monzo and B. Tydeman (Eds.) *Innovations in Parent-Infant Psychotherapy* (pp. 196-214). Karnac Books Ltd.

Daws, D. (1985). Two Papers on Work in a Baby Clinic: (I) Standing Next to the Weighing Scales. *Journal of Child Psychotherapy*, *11B*(2), 77–85.

Demerouti, E., Bakker, A. B., Nachreiner, F. and Schaufeli, W. B. (2001). The job demands-resources model of burnout. *The Journal of Applied Psychology*, *86*(3), 499–512.

Department of Health. (2015). *Future in mind Promoting, protecting and improving our children and young people's mental health andwellbeing*. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/414024/Childrens_Mental_Health.pdf

Department of Health and Social Care. (2021). *The best start for life: a vision for the 1,001 critical days.* https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/973112/The_best_start_for_life_a_vision_for_the_1_001_critical_days.pdf

Douglas, H. and Johnson, R. (2019). The Solihull Approach 10-Week Programme: A Randomised Controlled Trial. *Community Practitioner*, *92*(7), 45–47.

Elfer, P. (2012). Emotion in nursery work: Work discussion as a model of critical professional reflection. Early Years: *International Journal of Research and Development*, *32*(2), 129–141.

Elfer, P. and Page, J. (2015). Pedagogy with babies: perspectives of eight nursery managers. *Early Child Development & Care*, *185*(11–12), 1762–1782. https://doi.org/10.1080/03004430.2015.1028399

Emanuel, L. (2002). Deprivation × 3: The contribution of Organizational Dynamics to the 'Triple Deprivation' of Looked-After Children. *Journal of Child Psychotherapy*, *28*(2), 163–179.

Emanuel, L. (2011). Brief interventions with parents, infants, and young children: A framework for thinking. *Infant Mental Health Journal*, *32*(6), 673–686. https://doi.org/10.1002/imhj.20327

Emanuel, L. (2012). Holding on; being held; letting go: the relevance of Bion's thinking for psychoanalytic work with parents, infants and children under five. *Journal of Child Psychotherapy, 38*(3), 268–283. https://doi.org/10.1080/0075417X.2012.720101#.UZpNWaAgySo

Emanuel, L. (2019). Working with couples as parents and parents as couples In T. Baradon (Ed.), *Working with fathers in psychoanalytic parent-infant psychotherapy.* (pp. 117–123). Routledge.

Emanuel, R. (2021). Changing minds and evolving views: a bio-psycho-social model of the impact of trauma and its implications for clinical work. *Journal of Child Psychotherapy*, *47*(3), 376–401. https://doi.org/10.1080/0075417X.2021.2013927

Feldman Barrett, L. (2017). *How emotions are made*. Macmillan.

Felitti, V., Anda, R., Nordenberg, D., Williamson, D., Spitz, A., Edwards, V., Koss, M. &. Marks, J. (1998). Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults: The Adverse Childhood Experiences (ACE) Study. *American Journal of Preventive Medicine. 14*(4), 245–258.

Figley, C. R. (1995). Compassion fatigue as secondary traumatic stress disorder: An overview In C. R. Figley (ed.), *Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized* (pp. 1–20). Brunner-Routledge.

Figley, C. R. and Stamm, B. H. (1996). Psychometric review of Compassion Fatigue Self-Test In B. H. Stamm (ed.), *Measurement of stress, trauma, and adaptation* (pp. 127–130). Sidran Press.

Finlay, L. (2011). *Phenomenology for therapists : researching the lived world. [electronic resource]*. J. Wiley. https://search.ebscohost.com/login.aspx?direct=true&db=cat04005a&AN=tavi.40861&authtype=shib&site=eds-live&scope=site

Fonagy, P., Steele, M., Moran, G., Steele, H., and Higgitt, A. (1991). Measuring the Ghost in the Nursery: A Summary of the Main Findings of the Anna Freud Centre - University College London Parent-Child Study. *Bulletin of the Anna Freud Centre*, *14*(2), 115–131.

Fonagy, P. and Target, M. (1998). Mentalization and the changing aims of child psychoanalysis. *Psychoanalytic Dialogues, 8*(1), 87-114.

Fraiberg, S. (1982). Pathological Defenses in Infancy. *Psychoanalytic Quarterly*, *51*, 612–635.

Fraiberg, S. Adelson, E. and Shapiro, V. (1975). Ghosts in the Nursery: A Psychoanalytic Approach to the Problems of Impaired Infant Mother Relationships. *Journal of American Academy of Child Psychiatry, 14*(3), 387-421.

Freud, A., and The Institute of Psychoanalysis. (1993). *The Ego and the Mechanisms of Defence: Vol. Rev. ed*. Routledge. https://search.ebscohost.com/login.aspx?direct=true&db=nlebk&AN=369245&authtype=shib&site=eds-live&scope=site.

Freud, S. (1909). Analysis of a Phobia in a Five-Year-Old Boy. *The Standard Edition of the Complete Works of Sigmund Freud, 10*, 1-150.

Freud, S. (1920). Beyond the Pleasure Principle. *The Standard Edition of the Complete Works of Sigmund Freud, 18,* 1-64.

Freud, S. (1923). The Ego and the Id. *The Standard Edition of the Complete Works of Sigmund Freud, 19,* 1-66.

Freud, S. (1926). Inhibitions, Symptoms and Anxiety. *The Standard Edition of the Complete Works of Sigmund Freud, 20,* 87-175.

Frosh, S. (2012). *A Brief Introduction to Psychoanalytic Theory.* Palgrave Macmillan.

Freudenberger, H. J. (1977). Speaking from Experience. *Training & Development Journal*, *31*(7), 26-27.

GenderEYE. (2020). *Gender Diversification of the Early Years Workforce: Recruiting and Supporting MalePractitioners*.

https://gendereye.files.wordpress.com/2020/10/gendereye-final-end-of-project-report-28-oct.pdf

Geissmann, C. and Geissmann, P. (1998). *A History of Child Psychoanalysis.* Routledge.

Glaser, B. G. and Strauss, A. L. (1967). *The discovery of grounded theory. Strategies for qualitative research*. Weidenfeld and Nicolson.

Glass, C. and Minnotte, K. L. (2010). Recruiting and hiring women in STEM fields. *Journal of Diversity in Higher Education*, *3*(4), 218–229. https://doi.org/10.1037/a0020581

Glover, N. (2009). *Psychoanalytic aesthetics. An introduction to the British School*. The Harris Meltzer Trust.

Greenhalgh, T. and Peacock, R. (2005). Effectiveness and Efficiency of Search Methods in Systematic Reviews of Complex Evidence: Audit of Primary Sources. *British Medical Journal*, 331, 1064-1065. https://doi.org/10.1136/bmj.38636.593461.68

Gurion, M. (2008). Oedipal issues in under-fives families: creating a space for thinking In Emanuel, L. and Bradley, E. (Eds.) *"What can the matter be?" Therapeutic interventions with parents, infants, and young children.* (pp. 200-210). Karnac Books.

Henry, G. (1974). Doubly Deprived. *Journal of Child Psychotherapy*, *3*(4), 15–28.

Hewstone, M., Rubin, M., and Willis, H. (2002). Intergroup Bias. *Annual Review of Psychology*, *53*(1), 575. https://doi.org/10.1146/annurev.psych.53.100901.135109

Holmes, J. 2014. Countertransference in Qualitative Research: A Critical Appraisal. *Qualitative Research 14*(2), 166–83.

Hopkins, J. (1992). Infant-Parent Psychotherapy. *Journal of Child Psychotherapy*, *18A*(1), 5–17.

Hopkins, J. (2008). Infant-parent psychotherapy: Selma Fraiberg's contribution to understanding the past in the present In Emanuel, L. and Bradley, E. (Eds.) *"What can the matter be?" Therapeutic interventions with parents, infants, and young children.* (pp. 54-66). Karnac Books.

Hopkins, J. and Phillips, G. (2009). Some contributions of attachment theory and research In Lanyado, M., and Horne, A. (Eds.). *The handbook of child and adolescent psychotherapy. Psychoanalytic approaches* (2nd ed.). (pp. 38-50). Routledge.

Hubbard, F. O., and van IJzendoorn, M. H. (1991). Maternal unresponsiveness and infant crying across the first 9 months: A naturalistic longitudinal study. *Infant Behavior & Development*, *14*(3), 299–312. https://doi.org/10.1016/0163-6383(91)90024-M

Jones, A. (2006). Levels of change in parent-infant psychotherapy. *Journal of Child Psychotherapy. 32*(3), 295-311.

Jones, A. (2019). When working therapeutically with a baby's father is not possible In T. Baradon (Ed.), *Working with fathers in psychoanalytic parent-infant psychotherapy.* (pp. 154–168). Routledge.

Klein, M. (1946). Notes on Some Schizoid Mechanisms. *International Journal of Psycho-Analysis*, *27*, 99–110.

Klein, M. (1975). *Love, guilt and reparation and other works 1921-1945*. Hogarth Press and Institute of Psychoanalysis.

Laplanche, J. and Pontalis, J-B. (1988). *The Language of Psychoanalysis*. Karnac. (Original work published 1973).

Larkin, M. and Thompson, A. R. (2011). Interpretative phenomenological analysis in mental health and psychotherapy research In D. Harper & A. R. Thompson (Eds.), *Qualitative research methods in mental health and psychotherapy: A guide for students and practitioners* (pp. 101–116). Wiley-Blackwell.

Leiter, M. P. and Maslach, C. (1988). The Impact of Interpersonal Environment on Burnout and Organizational Commitment. *Journal of Organizational Behavior*, *9*(4), 297–308.

Lieberman, A. F. (1999). Negative Maternal Attributions: Effects on Toddlers' Sense of Self. *Psychoanalytic Inquiry*, *19*(5), 737–756. DOI: 10.1080/07351699909534274

Lieberman, A. F., Padrón, E., Van Horn, P., and Harris, W. W. (2014). Angels in the Nursery: The Intergenerational Transmission of Benevolent Parental Influences. *Attachment: New Directions in Psychotherapy and Relational Psychoanalysis*, *8*(2), 120–138.

Likierman, M. and Urban, E. (2009). The roots of child and adolescent psychotherapy in psychoanalysis In Lanyado, M., and Horne, A. (Eds.). *The handbook of child and adolescent psychotherapy. Psychoanalytic approaches* (2nd ed.). (pp. 15-26). Routledge.

Maslach, C. (2001). What Have We Learned about Burnout and Health? *Psychology & Health*, *16*(5), 607. https://doi.org/10.1080/08870440108405530

Mathieu, F. (2007). Running on empty: Compassion fatigue in health professionals. *Rehab & Community Care Medicine,* 1-5. http://www.compassionfatigue.org/pages/RunningOnEmpty.pdf

McCann, I. L. and Pearlman, L. A. (1990). Vicarious Traumatization: A Framework for Understanding the Psychological Effects of Working with Victims. *Journal of Traumatic Stress*, *3*(1), 131–149. https://doi.org/10.1007/BF00975140

Meins, E., Fernyhough, C., Arnott, B., Leekam, S. and de Rosnay, M. (2013). Mind-mindedness and theory of mind : mediating roles of language and perspectival symbolic play., *Child development., 84*(5), 1777-1790.

Miller, L. (1992). The Relation of Infant Observation to Clinical Practice in an under Fives Counselling Service. *Journal of Child Psychotherapy*, *18A*(1), 19–32.

Miller, L. (2008). The relation of infant observation to clinical practice in an under-fives counselling service In Emanuel, L and Bradley, E. (Eds.) *"What can the matter be?" Therapeutic interventions with parents, infants and young children.* (pp*. 38*-53). Karnac Books.

Morris, H. (2020). *Stories of Hope: Finding Inspiration in Everyday Lives.* Manilla Press.

Murray, L. (2014). *The Psychology of Babies: How relationships support development from birth to two.* Constable & Robinson Ltd.

Music, G. (2017). *Nurturing Natures : Attachment and Children's Emotional, Sociocultural and Brain Development.* 2nd edn. New York: Routledge.

Music, G. (2019). *Nurturing children: From trauma to growth using attachment theory, psychoanalysis and neurobiology*. Routledge.

National Health Service. (2019). *NHS Long Term Plan*. https://www.longtermplan.nhs.uk/wp-content/uploads/2019/08/nhs-long-term-plan-version-1.2.pdf

Newell, J. M., Nelson-Gardell, D. and MacNeil, G. (2016). Clinician Responses to Client Traumas : A Chronological Review of Constructs and Terminology. *Trauma, Violence & Abuse*, *17*(3), 306–313.

Onions, C. (2009). Parent-infant psychotherapy In Lanyado, M., and Horne, A. (Eds.). *The handbook of child and adolescent psychotherapy. Psychoanalytic approaches* (2nd ed.). (pp. 220-234). Routledge.

O'Rourke, J. (2018, September). *Dilys Daws Interview*. MindinMind. https://mindinmind.org.uk/interviews/dilys-daws-interview/

Parent-Infant Foundation (2019). *Rare Jewels: specialised parent-infant relationship teams in the UK.* https://parentinfantfoundation.org.uk/wp-content/uploads/2019/09/PIPUK-Rare-Jewels-FINAL.pdf

Parent-Infant Foundation. (2021). *Where are the infants in children and young people's mental health? Findings from a survey of mental health practitioners*. https://parentinfantfoundation.org.uk/wp-content/uploads/2021/06/PIF-Where-are-the-Infants-in-CYP-MH-26-May.pdf

Parent-Infant Foundation. (2023). *What are specialised parent-infant teams?* https://parentinfantfoundation.org.uk/our-work/what-is-a-parent-infant-team/

Passmore, S., Hemming, E., McIntosh, H. C. and Hellman, C. M. (2020). The Relationship Between Hope, Meaning in Work, Secondary Traumatic Stress, and Burnout Among Child Abuse Pediatric Clinicians. *Journal of Applied Communications*, *24*(1), 29–34. https://doi.org/10.7812/TPP/19.087

Pozzi, M. E. (2003). *Psychic hooks and bolts. Psychoanalytic work with children under five and their families*. Karnac Books.

Pozzi-Monzo, M. (2017). The practice of psychoanalytic parent–infant psychotherapy. Claiming the baby. *Journal of Child Psychotherapy*, *43*(2), 295–299. https://doi.org/10.1080/0075417X.2017.1326971

Pozzi-Monzo, M. E., Lee, A., and Likierman, M. (2012). From reactive to reflective: Evidence for shifts in parents' state of mind during brief under-fives psychoanalytic psychotherapy. *Clinical Child Psychology and Psychiatry, 17*(1), 51-164. https://doi.org/10.1177/1359104511403682

Public Health England. (2021). *Care continuity between midwifery and health visiting services: principles for practice*. https://www.gov.uk/government/publications/commissioning-of-public-health-services-for-children/care-continuity-between-midwifery-and-health-visiting-services-principles-for-practice

Radey, M. and Figley, C. R. (2007). The Social Psychology of Compassion. *Clinical Social Work Journal*, *35*(3), 207–214. https://doi.org/10.1007/s10615-007-0087-3

Reed, J and Parish, N. (2021). *Working for babies Lockdown: Lessons from local systems.* Parent-Infant foundation. https://parentinfantfoundation.org.uk/wp-content/uploads/2021/01/210115-F1001D-Working-for-Babies-Report-FINAL-v1.0-compressed.pdf

Reid, K., Flowers, P. and Larkin, M. (2005). Exploring lived experience. *The Psychologist*, *18*(1), 20–23.

Robertson, J. (1971). Young Children in Brief Separation - A Fresh Look. *Psychoanalytic Study of the Child, 26,* 264–315.

Rubin, R. (2023). *The Creative Act: A Way of Being*. Canongate Books.

Rustin, M. E., and Emanuel, L. (2010). Observation, reflection and containment: A psychoanalytic approach to work with parents and children under five In Lemma, A. and Patrick, M. (Eds.) *Off the couch: Contemporary psychoanalytic applications* (pp. 82-97*)*. Taylor & Francis.

Rustin, M. J. (1989). Observing Infants: Reflections on Methods In Miller, L., Rustin, M. E., Rustin, M. J., and Shuttleworth, J. (Eds.) *Closely Observed Infants*. (pp. 52-75). Duckworth.

Salomonsson, B., Baradon, T., and von Klitzing, K. (2019). Three themes about fathers in parent-infant psychotherapy In T. Baradon (Ed.), *Working with fathers in psychoanalytic parent-infant psychotherapy.* (pp. 154–168). Routledge.

Salzberger-Wittenberg, I. (1970). *Psycho-Analytic Insight and Relationships : A Kleinian Approach*. Routledge.

Schore, A. N. (2012). *The science of the art of psychotherapy*. W.W. Norton.

Shonkoff, J. and Phillips, D. (2000). *From neurons to neighborhoods. The science of early childhood development*. National Academy Press.

Smith, J. A., Flowers, P. and Larkin, M. H. (2009). *Interpretative phenomenological analysis: Theory, method and research*. SAGE.

Solms, M. (2021). *The Hidden Spring*. London: Profile Books Ltd.

Spillius, E. B., Milton, J., Garvey, P., Couve, C. and Steiner, D. (2011). *The new dictionary of Kleinian thought* (1st ed.). Routledge.

Stevenson, S. (2012). Race and Gender Dynamics as an Organisational Defence against Anxiety within a Specialist Multi-Disciplinary Child and Family Assessment Service. *Organizational and Social Dynamics*, *12*(2), 131–144.

Symington, J., and Symington, N. (1996). *The clinical thinking of Wilfred Bion*. Routledge.

Stern, D. (1995). *The motherhood constellation.* New York: Basic Books.

Tajfel, H. (1970). Experiments in Intergroup Discrimination. *Scientific American*, *223*(5), 96–103.

Tuffour, I. (2017). A Critical Overview of Interpretative Phenomenological Analysis: A Contemporary Qualitative Research Approach. *Journal of Health Care Communications. 2*(4), 1-5. https://www.primescholars.com/articles/a-critical-overview-of-interpretative-phenomenological-analysis-a-contemporary-qualitative-research-approach-96276.html

Turgoose, D. and Maddox, L. (2017). Predictors of compassion fatigue in mental health professionals: A narrative review. *Traumatology*, *23*(2), 172–185.

Watillon, A. (1993). The Dynamics of Psychoanalytic Therapies of the Early Parent-Child Relationship. *International Journal of Psycho-Analysis*, *74*, 1037–1048.

Williams, G. (1997). Reflections On Some Dynamics Of Eating Disorders: ‘No Entry’ Defences And Foreign Bodies. *International Journal of Psycho-Analysis*, *78*, 927–941.

Williams, G. (1999). On Different Introjective Processes and the Hypothesis of an “Omega Function.” *Psychoanalytic Inquiry*, *19*(2), 243–253.

Willig, C. (2008). *Introducing qualitative research in psychology* (2nd ed.). Open University Press.

Winnicott, D. (1960). The Theory of the Parent-Infant Relationship, *International Journal of Psycho-Analysis*, *41*, 585-595.

Winnicott, D. W. (1965). *The Maturational Processes and the Facilitating Environment: Studies in the Theory of Emotional Development*. The Hogarth Press and the Institute of Psycho-Analysis.

Winnicott, D. (2021). *The child, the family, and the outside world.* Penguin Classics. (Original work published 1964).

Winnicott, D.W. (2005). *Playing and Reality*. Tavistock Publications. (Original work published 1971).

Wittenberg, I. (2008) Brief work with parents of infants In Emanuel, L and Bradley, E. (Eds.) *“What can the matter be?" Therapeutic interventions with parents, infants and young children.* (pp. 15-37). Karnac Books.

World Health Organisation. (2015). WHO recommendations on health promotion interventions for maternal and newborn health 2015 http://apps.who.int//iris/bitstream/10665/172427/1/9789241508742_report_eng.pdf.

Yardley, L. (2000). Dilemmas in Qualitative Health Research. *Psychology & Health*, *15*(2), 215.

Appendices

Appendix 1 – Ethical approval

To:

- CHURCHILL, David ([redacted] PARTNERSHIP NHS FOUNDATION TRUST)

Cc:

- Jenifer Wakelyn <[redacted]@tavi-port.nhs.uk>;
- Brinley Yare <[redacted]@Tavi-Port.ac.uk>;
- Phillip McGill <[redacted]@tavi-port.nhs.uk>;
- Sarina Campbell <[redacted]l@tavi-port.nhs.uk>;
- Academic Quality <[redacted]@Tavi-Port.nhs.uk>

Fri 15/10/2021 16:32

Dear David,

I am pleased to inform you that subject to formal ratification by the Trust Research Ethics Committee (TREC) your application has been approved. This means you can proceed with your research.

Please note that any changes to the project design including changes to methodology/data collection etc, must be referred to TREC as failure to do so, may result in a report of academic and/or research misconduct.

For information governance purposes and in line with the Trust policies, please be advised that in order to conduct research/interviews using online video conferencing you must contact TEL (copied) to set up a zoom account. With regards to privacy, please ensure that meetings with yourself and your participants are conducting in a safe environment and that confidentiality is maintained.

Your updated TREC form is attached

If you have any further questions or require any clarification do not hesitate to contact me.

May I take this opportunity of wishing you every success with your research.

Regards,

Paru

Mrs Paru Jeram
Senior Quality Assurance Officer
(Research Degrees and Research Ethics)
Academic Governance and Quality Assurance
https://tavistockandportman.nhs.uk/research-and-innovation/doing-research/student-research/

Appendix 2 – Participant information sheet

The Tavistock and Portman
NHS Foundation Trust

Participant Information Sheet

Research Project Title:

What can be learned from referrers' experiences of using [redacted]: a parent infant mental health pilot project for children under 5?

What is this project about?

This project investigates parents' and referrers' experience of using the [redacted] pilot project to inform understanding of what it feels like to use the service. I am interested in referrers' experiences of what it was like to go through the referral process at [redacted], including presenting to the Consultation Group, the feedback received, and the treatment offered.

What will participating in this project involve?
Participants are asked to take part in one online semi-structured interview, which will last for up to 60 minutes and will be recorded. Interviews will take place using Microsoft Teams. During the interview you will be asked to reflect on your experience of using [redacted] as a referrer.

What are the possible benefits of taking part in this project?
You may benefit from the opportunity to think about and make sense of your experience of using [redacted] and how this affected your understanding and relationship with the child and family you referred. Your involvement will add to the understanding in the field of child and adolescent psychotherapy and working with parents and under-fives.

What will happen to the data collected?
Each interview will be recorded and transcribed. As the number of participants is likely to be small, there is a higher possibility that participants could be identified. Information from the interviews about you or the cases you talk about will be anonymised to prevent this and participant details will be kept highly confidential. Electronic data will be stored on a password protected computer. All audio/video recordings from both parents and referrers will be analysed together and then destroyed after completion of the project within 2 years, in accordance with Tavistock and Portman NHS Foundation Trust GDPR protocols.

What will happen to the results of the project?

The results of this study will be used in my Professional Doctorate thesis. It may also be used in future academic publications and presentations.

Disclaimer
You are not obliged to take part in this study and are free to withdraw from the project up until your interview is processed. Whether or not you would like to participate in this study will have no impact on your access to [redacted] or the NHS.

This research has been formally approved by the Tavistock and Portman Trust Research Ethics Committee.

If you have any concerns about the conduct of the researcher or any other aspect of this research project, please contact Beverley Roberts (Interim Head of Academic Governance and Quality Assurance (academicquality@tavi-port.nhs.uk). Alternatively, you can contact my research supervisor, Dr Jenifer Wakelyn (jwakelyn@tavi-port.nhs.uk).

Contact details:
David Churchill
Trainee Child and Adolescent Psychotherapist
Tavistock and Portman NHS Foundation Trust and University of Essex
david.churchill2@nhs.net

Appendix 3 – Participant consent form

The Tavistock and Portman
NHS Foundation Trust

Participant Consent Form

Project Title: What can be learned from referrers' experiences of using [redacted]: a parent-infant mental health pilot project for children under 5?

Name of Researcher: David Churchill (david.churchill2@nhs.net)

I confirm that I have read and understood the participant information sheet, which provides details of the nature of the research and how I will be asked to participate.	
I understand that my agreement to participate is voluntary and that I am free to withdraw it without giving a reason, until my data is processed.	
I understand my interview will be recorded and transcribed by the researcher, as described in the Participant Information Sheet.	
I understand the information I provide in the interviews will be kept confidential by the researcher, unless the researcher believes someone to be at risk.	
I understand the results of this research may be published in the form of a thesis, journal article, academic publications or presentations, but no personally identifying details will be included and that stringent steps will be taken to maintain confidentiality and anonymity.	
I understand the interviews may involve the risk of emotional upset or discomfort, that I can stop the interview at any point and that I will be offered a chance to debrief after the interview has concluded.	

I confirm that I understood the content of this document and I consent to participate in this research study, which is part of the Professional Doctorate in Child and Adolescent Psychoanalytic Psychotherapy

Participant's Name (Printed):_____

Participant's Signature:_____ Date:_____

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

Appendix 4 – Debrief letter

The Tavistock and Portman
NHS Foundation Trust

Dear Participant,

Thank you for taking part in my doctoral research project. Your participation is both valuable and much appreciated.

The information collected during your interview has been stored securely and will be anonymised so that it is not possible to identify you. All your information will be erased within a period of 2 years.

Thinking and speaking about your journey with [redacted] may have brought up unforeseen questions or thoughts for you and you may like to speak to someone. If this is the case, please contact the Patient Advice and Liaison Service [redacted] or [redacted]

You can also speak with me, (david.churchill2@nhs.net), or my manager, Dr [redacted] if you have any questions or would find it helpful to debrief with either of us.

If you have any concerns about my conduct as researcher or any other aspect of this research project, please contact my research supervisor, Dr Jenifer Wakelyn (JWakelyn@tavi-port.nhs.uk) Alternatively, you could contact Simon Carrington, Head of Academic Governance and Quality Assurance (academicquality@tavi-port.nhs.uk).

Kind regards, David Churchill

Trainee Child and Adolescent Psychotherapist

Tavistock and Portman NHS Foundation Trust and University of Essex

david.churchill2@nhs.net

Appendix 5 – Indicative interview schedule

The Tavistock and Portman
NHS Foundation Trust

Indicative Interview Schedule

ProfDoc research project title: What can be learned from the parent experience of using [redacted]: a parent-infant mental health pilot project for children under 5?

Researcher: David Churchill

Semi-structured interview schedule parents and referrers who have used the [redacted] Under-Fives pilot project.

Research question: What can be learned from the parent experience of using [redacted]: a parent-infant mental health pilot project for children under 5?

Part 1 – Introduction

Explain the time frame of the interview.
Create a rapport and put the participant at ease, so far is possible.
Check recording devices
Check the participant has signed the consent form and answer any questions they may have

Part 2 – Interview

Ask the pre-prepared open-ended questions to create a rich discourse.
Ask follow-up questions to gain more data and/or follow the trajectory of the participants thinking, where relevant.

Part 3– Ending and Debrief

Ensure that all relevant questions have been asked and that the participant has had the opportunity to add anything they feel is relevant but has not been addressed in my questions.

Ensure that the participant has an opportunity to ask me any questions they may have in the debrief.
Ensure the participant feels emotionally settled and is safe to leave or stop the interview.

Questions for referrers

1. **Can you tell me about the child/children you referred to [redacted]?**

- Why were they brought to the service?
- What concerned you about this child to want to refer them to the service?
- What concerned you about your parent-child relationship?

2. **What were you hoping for from the service?**

- How do the outcomes compare to your hopes?
- How do you feel about how things are going after using the service?

3. **What would you have liked to have known looking back to when you referred to the service?**

- Would you have changed anything?
- How many times have you referred?
- What advice would be helpful for professionals who are about to refer?

4. **What do you think was effective in the service?**

- How did this lead to change?
- How do you think this could be done better?

5. **What do you think was not so effective?**

- What do you feel could have been done better?
- Do you have any suggestions?

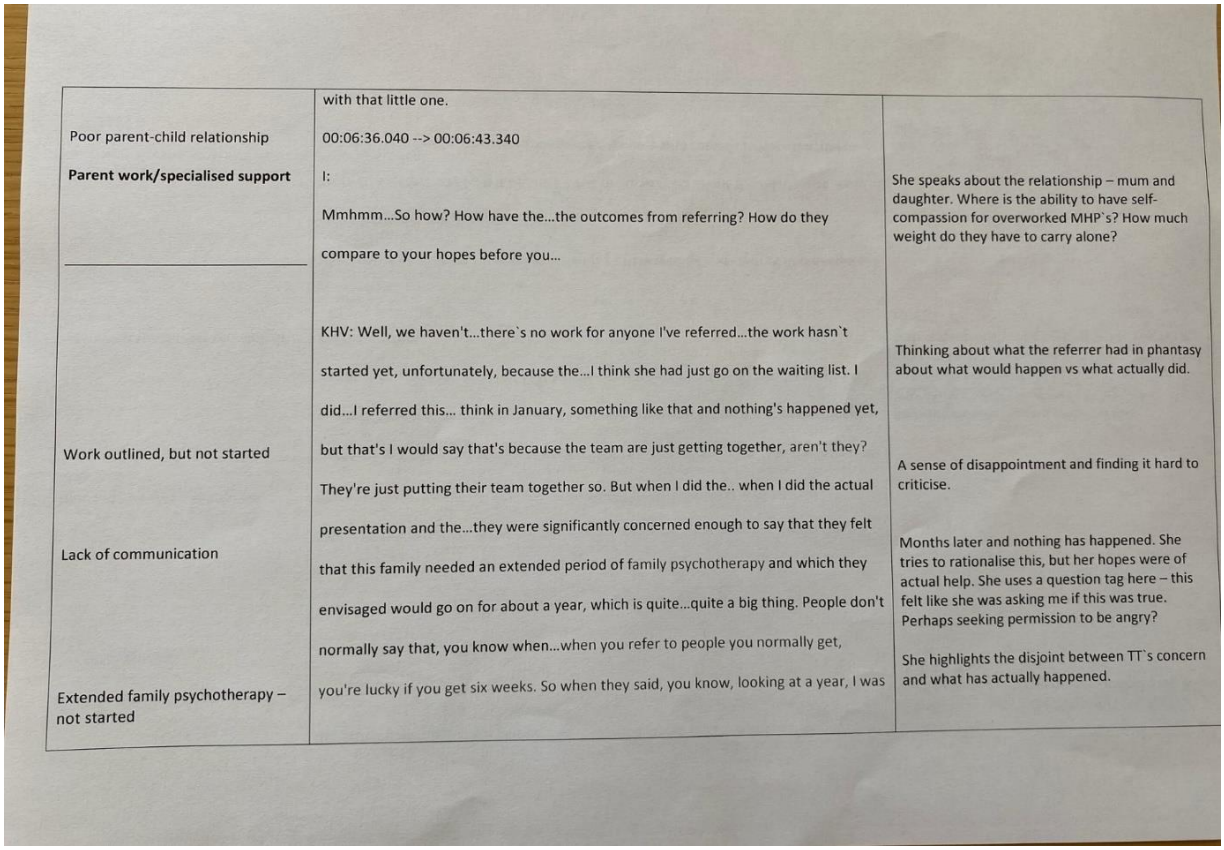
6. **How would you sum up/explain your experience of the service to another professional thinking of referring?**

- What would you like to have been told or asked if you could go back in time?

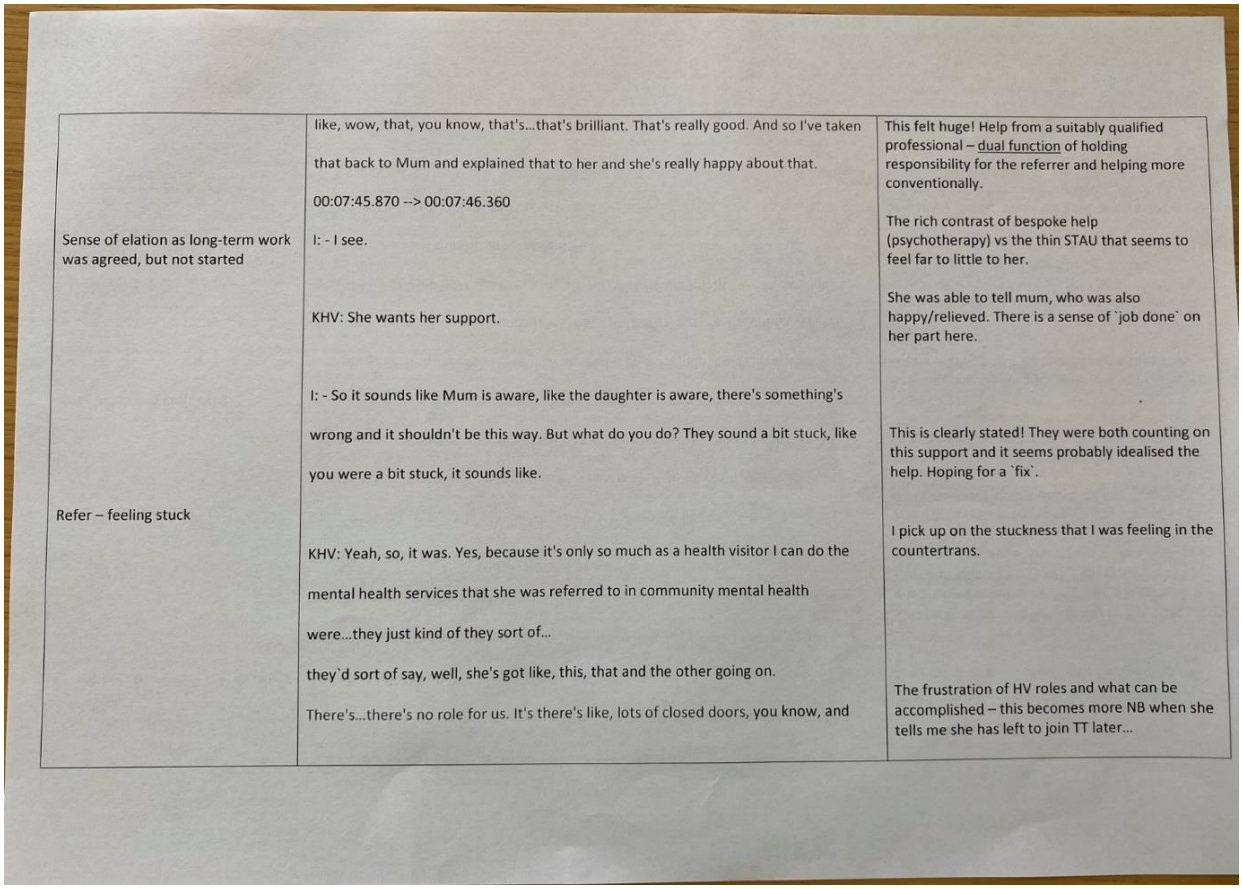
7. **Is there anything you would like to add?**

- Is there something important that I have not asked you about – positive or negative?

Appendix 6 – Transcript (including notes and themes)



	with that little one.	
Poor parent-child relationship	00:06:36.040 --> 00:06:43.340	
Parent work/specialised support	I:	She speaks about the relationship – mum and daughter. Where is the ability to have self-compassion for overworked MHP`s? How much weight do they have to carry alone?
	Mmhmm...So how? How have the...the outcomes from referring? How do they compare to your hopes before you...	
	KHV: Well, we haven't...there`s no work for anyone I've referred...the work hasn`t started yet, unfortunately, because the...I think she had just go on the waiting list. I did...I referred this... think in January, something like that and nothing's happened yet, but that's I would say that's because the team are just getting together, aren't they? They're just putting their team together so. But when I did the.. when I did the actual presentation and the...they were significantly concerned enough to say that they felt that this family needed an extended period of family psychotherapy and which they envisaged would go on for about a year, which is quite...quite a big thing. People don't normally say that, you know when...when you refer to people you normally get, you're lucky if you get six weeks. So when they said, you know, looking at a year, I was	Thinking about what the referrer had in phantasy about what would happen vs what actually did. A sense of disappointment and finding it hard to criticise. Months later and nothing has happened. She tries to rationalise this, but her hopes were of actual help. She uses a question tag here – this felt like she was asking me if this was true. Perhaps seeking permission to be angry? She highlights the disjoint between TT`s concern and what has actually happened.
Work outlined, but not started		
Lack of communication		
Extended family psychotherapy – not started		



	like, wow, that, you know, that's...that's brilliant. That's really good. And so I've taken that back to Mum and explained that to her and she's really happy about that. 00:07:45.870 --> 00:07:46.360	This felt huge! Help from a suitably qualified professional – dual function of holding responsibility for the referrer and helping more conventionally.
Sense of elation as long-term work was agreed, but not started	I: - I see. KHV: She wants her support.	The rich contrast of bespoke help (psychotherapy) vs the thin STAU that seems to feel far to little to her. She was able to tell mum, who was also happy/relieved. There is a sense of `job done` on her part here.
Refer – feeling stuck	I: - So it sounds like Mum is aware, like the daughter is aware, there's something's wrong and it shouldn't be this way. But what do you do? They sound a bit stuck, like you were a bit stuck, it sounds like. KHV: Yeah, so, it was. Yes, because it's only so much as a health visitor I can do the mental health services that she was referred to in community mental health were...they just kind of they sort of... they`d sort of say, well, she's got like, this, that and the other going on. There's...there's no role for us. It's there's like, lots of closed doors, you know, and	This is clearly stated! They were both counting on this support and it seems probably idealised the help. Hoping for a `fix`. I pick up on the stuckness that I was feeling in the countertrans. The frustration of HV roles and what can be accomplished – this becomes more NB when she tells me she has left to join TT later...

Appendix 7 – Developing themes

Interview 1 – Kirsten HV

Themes	Page	Quote
Q1 - Reasons for referring		
Intergenerational transmission of trauma	1	vast history of trauma and in mum's life and she…she had a really difficult upbringing with her alcoholic parent and
Abusive relationships	1	the mother of this child jumped around different relationships and some of which were abusive
Domestic violence- Conceived through assault – rape	1-2	the little girl was conceived through an assault.
Physical chastisement	2	**000**
(Parent-child relationship) - Erratic parental behaviour	2	Mum would flit from being very lovely, sensitive, kind of wanting to be a really good mum at one moment
Child protection plan	3	she ended up going on a child protection plan because mum phoned a mental health helpline at one point and was heard to really scream and shout at her daughter
Mum was worried she might hurt her child**(Parent-child relationship)**	3	and she also told me that she was worried about what she was…would do, even though she didn't want to.
Re-enactment – **intergenerational transmission**	3	So she's trying really hard to not be her mother, but at the same time, because of the trauma that's happened to her, she is becoming her mother
Parental guilt/shame (Complexity?) (Parent-child relationship)	3	she feels huge guilt and remorse and…and that just compounds the issue
Child maturing too fast **(Parent-child relationship)**	3-4	developing this kind of carer role "Don't…don't do that to me, Mummy. I'm only two!"
Child taking the parent role**(Parent-child relationship)**	4	"Why don't you lay down mummy and have a rest?"
No health issues, but staying involved (Parent-child relationship)	4	There was no health issues for…for Chloe, but I would just be watching this kind of…uh, just scary parenting. Is it kind of almost like I would, I would feel on edge

		sitting there because I didn't know how she was gonna react.
Intergenerational transmission of trauma Attachment and bonding Re-enactment **DV** - Conceived though and assault **Dangerous males**	4-5	So I did the referral to TT because I felt that the issues were all around attachment and bond and with Mum's own parenting and relationship styles, but also obviously with the little one…and I felt that it was compounded by the fact that she was born in, you know, conceived through an assault and we weren't, were never allowed to speak about that man
Intergenerational transmission of trauma (Parent-child relationship)	5	significant concerns regarding the relationship, and I felt that this relationship, that the little one was having with a mum, was definitely gonna have an impact on her relationships she has as she gets older and I felt that we needed some support with that. So that's why I did the referral.
Parent-child relationship **Parent work/specialised support (Q2)**	6 6	When I referred I did it because I was really worried about the relationship now and also I felt that Mum needed specialized support with regards to her attachment with that little one.

Appendix 8 – Online information from the pilot project`s website

[redacted] [redacted]

A pilot project to support early family relationships for parents, carers, infants and children under 5 across [redacted].

[redacted] supports parent-infant mental health across [redacted] by strengthening parents' confidence and their capacity to understand and enjoy their relationship with their baby or child. It is for professionals and anyone working with a child under 5 who would like more support in their work. [redacted] works with existing services and brings together experts across agencies.

This pilot is for parents and carers:

- who are struggling in relationships with infants and children under 5
- who struggle to feel emotionally connected with their infants or young children
- whose young children struggle to separate
- with experiences that are impacting on parenting
- who have concerns about an infant or young child's emotional development
- mothers' who experienced difficult pregnancies
- family experience of trauma

What is [redacted]?

Supporting and strengthening relationships between babies and their carers.

[redacted] offers direct work with parents and carers, including specialist therapeutic intervention where families may be experiencing difficulties. The multi-disciplinary team also use their expertise to help the local workforce understand and support parent-infant relationships

For information and advice email the [redacted] team.

- "Investing in the emotional wellbeing of our babies is a wonderful way to invest in the future"
- "Early relationships shape babies' social and emotional development and influence many key outcomes"
- "Early relationships between babies and their parents are incredibly important for building healthy brains"

Quotes are from the Patient Infant Foundation.

[redacted] consultation group

The [redacted] consultation group is for professionals who are working with a parent-infant or child relationship they are concerned about.

The consultation group is made up of infant mental health specialists across [redacted]. The referrer will talk to the group about the parent-infant or child relationship and the group, using the language of the Solihull Approach (containment, reciprocity and behaviour management) will generate a plan of the next positive steps.

Following the group a written version of these understandings are sensitively generated for the referrer to feed back to the family.

Professionals are also encouraged to contact the [redacted] team if they want to talk through the case before they decide to refer to the group.

The child and family may then be referred to services such as:

- health visiting
- early help
- perinatal mental health
- special parenting
- WILD parenting
- Homestart [redacted]
- [redacted], access to psychological therapies
- First Light provide support for people who have been affected by domestic abuse and sexual violence
- Valued lives
- CAMHS primary mental health
- Play and art psychotherapy project for short term therapeutic intervention for 3 to 5-year-olds

The family may receive interventions from [redacted]:

- Watch me play

Resources

- [redacted] information for parents leaflet
- Watch me play manual for parents
- CAMHS early health hub referral form