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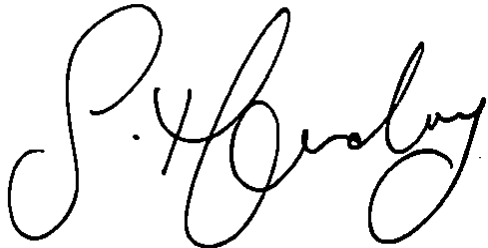
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GHOSTS IN THE WAITING ROOM: Understanding the impact of CAMHS-based psychoanalytic psychotherapy on biological sibling relationships when one child is in treatment and others are on the waiting list? A qualitative study of parents' perspectives.

Sharon Hendry

A thesis submitted as a requirement of the University of Essex and the Tavistock and Portman NHS Foundation Trust for the Professional Doctorate in Child and Adolescent Psychoanalytic Psychotherapy

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For *all* my siblings – present and absent: ‘*All for one and one for all.*’ Author quoting from Dumas, A. (1844)

‘*Siblings provide a way of learning to love and hate the same person.*’ Mitchell, J. (2003)

Abstract

The aim of this study is to explore the impact of CAMHS-based psychoanalytic psychotherapy on sibling relationships when one child is accessing treatment and others remain on the waiting list.

Four caregivers of siblings who have lived experience of this dynamic over a period of at least one year in a CAMHS clinic were interviewed using a semi-structured technique. Verbatim transcripts of the interviews were then analysed using Interpretative Phenomenological Analysis (IPA) to examine the parents' perspectives of the siblings' experience when one was receiving treatment and one waited.

Four Group Experiential Themes (GETs) were identified, each providing a rich description of both siblings and carers lived experience. They are: Sibling Inequality and the Struggle to be Seen; The Burden of Care and Blurred Identity; Navigating Systems of Support and Disappointment and Making Sense of Past Trauma in Present Relationships.

Key findings suggest that institutional practices, such as waiting lists, can actively reproduce feelings of rivalry and exclusion. This highlights the fact that sibling inequality is not merely a component of the internal world, but one that can be co-constructed by external social and institutional frameworks. The research also illuminated the invisible weight borne by parents and kinship carers, demonstrating how systemic failings can intensify the burden of care.

Key words: Siblings; Psychotherapy; CAMHS; Waiting Lists; Parental Perspectives; Relationships; Psychoanalysis.

Confidentiality

All names and distinguishing details of the patients and families described in this paper have been changed in order to maintain confidentiality.

Copyright

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Chapter 1: Introduction

This study is an Interpretative Phenomenological Analysis (IPA) (2022) of the impact of CAMHS-based psychoanalytic psychotherapy on biological sibling relationships when one child is in treatment and others are on the waiting list. This chapter presents the aims of the study while offering some background information on how and why the topic was conceived. It also outlines key reference terms and discusses the value the study hopes to bring both to psychoanalytic psychotherapy and the UK's child and adolescent mental health services (CAMHS).

1.1: Aims and Objectives

The overall aim of this thesis is to explore what happens to sibling relationships when one is accessing psychoanalytic psychotherapy while another has to wait. It is a small-scale qualitative research study which aims to give voice to children's lived experiences through their parents' perspectives. Throughout this study, all names have been changed to protect the identity of any participants and patients mentioned.

1.2: Why siblings?

The sibling relationship is often the first we have with someone of our own generation and - barring complications - is also the relationship which endures the longest, sometimes outlasting ties with parents and even partners. So why is its place in psychoanalysis, clinical thinking and research in general so modest?

As a trainee child and adolescent psychoanalytic psychotherapist, I could see the sibling dynamic was alive in so many of the external *and* internal worlds of my patients and yet it had no dedicated place in the training syllabus and was rarely factored into multi-disciplinary team (MDT) thinking within the CAMHS clinic where I worked.

A cursory literature review also revealed the sibling relationship is a surprisingly unexplored terrain, and I could only find one other research document on children's experience of waiting for CAMHS treatment. However, it was not focussed on sibling dynamics.

While this research project began to percolate in my mind, I also wondered why I had homed in on this aspect of my patients' psyches in particular. What was it about siblings that resonated with me? I tried to adopt a reflexive approach throughout the initial investigations into my topic of choice and came to the conclusion that a fundamental part of my own identity is bound up with my own sibling role.

Guillemin and Gillam (2004: Sage Publications) define a reflexive researcher as 'one who is aware of all these potential influences and is able to step back and take a critical look at his or her own role in the research process. My own family comprises a complex dynamic in which I am the youngest daughter of four children (a brother and three sisters). I was born 18 and 16 years respectively after my brother and sister from my mother's first marriage. After meeting my father and embarking on a second marriage when my eldest siblings were in their mid-teens, my parents went on to complete a kinship adoption of a 4-year-old girl before conceiving me 4 years later.

Despite our assorted genetics, our sibling group was united in many shared experiences, and we had a strong sense of togetherness which was simultaneously ruptured and tested when

my brother was killed in a motorbike accident aged 28. I was just 10 years old and from that moment on, my sisters and I lived in the shadow of a sibling who was ever present in our minds yet absent in reality. As I reflect on this dynamic, it is interesting to see how I have been led to this topic of interest in my clinical work – the idea of a sibling ghost who is at the same time present and absent.

I am also mindful of identifying with a concept of a sibling who is treated differently given that my father insisted on sending me to an elite private school despite the fact that my siblings had attended state schools. The concrete reason for this was that I was being failed in the education system at a particular moment in time and was not able to achieve my full potential but the reality for me was a significant period of formative life experience set apart from my siblings.

The school was not an easy environment to navigate and yet I felt I had to show gratitude and humility for something special (and expensive) I had been given and perform accordingly. On reflection, I have spent a good deal of my adult life feeling guilty for the so-called special treatment I was given in comparison to my siblings. I have dealt with those difficult feelings by trying to compensate in concrete ways – for instance financially – and downplaying my subsequent successes. Perhaps this life experience meant I was more unconsciously attuned to perceiving these dynamics in my own patients, many of whom – like me – have been set apart from their siblings in a different system (namely CAMHS) while living side-by-side in the same household.

1.3: Why the impact of waiting on siblings?

I was only a few months into my clinical training as a psychoanalytic child and adolescent psychotherapist when I realised that several of my patients had brought an unscheduled and unannounced visitor into the treatment room with them in the form of a sibling. Many of these uninvited ‘ghosts’ were also poised to join the CAMHS waiting list. They remained silent and invisible for the duration of the sessions but were no less present in the conscious and unconscious processes which played out.

In both transference and countertransference processes, I began to notice a range of emotions in relation to sibling dynamics. Sometimes I was aware of feelings of survivors’ guilt in my patients – a sense of being unfairly prioritised for help. At other times there were signs of envy in relation to siblings who were not being put through the same rigours of emotional labour. In other words, they had not been typecast as the ‘person with mental health problems’ in the family. Alongside each child’s individual CAMHS assessment formulation, there was an additional picture building in my mind; a complex and fascinating narrative centred on sibling relationships.

For example, one of my first weekly cases was a 7-year-old boy called Brian with a history of neglect and domestic violence. His 13-year-old sister had already completed psychotherapy treatment in CAMHS and his 6-year-old brother was poised for referral. On occasions, Brian demonstrated a sense of frustration in feeling singled out within his family constellation as the ‘naughty child’ – a label affirmed in his mind by the link to CAMHS. At other times, he conveyed deep anxiety aligned with the idea of moving along a CAMHS conveyor belt and potentially needing to vacate the space with his therapist when his younger brother took up a

position on the waiting list. ‘Will he see you too? Will he come to this room?’ were repeated refrains.

As the therapy progressed, his mind invested in a more tantalising position within his sibling group; whereby he pointed to the fact that his siblings were waiting in the carpark while he embedded himself in the therapy room complete with a chocolate-enriched picnic provided by his mother. He would highlight the fact that he was getting all the delicious food on the inside while they starved outside.

Further into the M80 training, my first intensive patient – a 9-year-old boy called Roland – began to introduce his 6-year-old sister Katie into the clinical material after just one or two sessions. Both are looked after children subject to a Special Guardianship Order (SGO) due to circumstances of considerable neglect and domestic violence. They have endured trauma side-by-side and yet Roland was referred to CAMHS first simply because he is the eldest sibling. The limited capacities of his older guardians meant two of his three weekly sessions had to take place in his primary school and he would regularly attempt to orchestrate an actual sighting of his younger sister during our transitions to and from the therapy room. ‘Look, there’s Katie,’ he would enthuse, pointing to a mass of children along the corridor, ‘Can you see my sister? There she is – over there!’ Later, he would wonder when or if I might become her therapist. Alongside his efforts to link her with me and to make sure I linked the two of them in my mind, there were also revelations of regular fights between them – the evidence of which were sometimes plain to see in significant scratch marks on Roland’s body.

Finally, alongside an experienced colleague, I undertook a 5-part State of Mind Assessment (SOMA) with 3 sisters aged 11, 9 and 8. All were on a child protection plan due to severe

neglect. Strong themes of envy and rivalry played out in the assessment process and psychotherapy was indicated for all the children. However, limitations in the service provision meant there was only space for one child to begin therapy with me. A painful discussion ensued after I presented the case in a child psychotherapy discipline meeting, and a decision was made to triage the eldest girl first. Subsequently, she spent several weeks in therapy while her sisters waited to re-join her in the clinic. They eventually spent a year in weekly therapy with my colleagues before being discharged, greatly improved but not entirely stable.

Meanwhile, thanks to an opportunity presented by my training requirements, their elder sister was able to remain in therapy with me on a new timetable of thrice weekly sessions. Once again, difficult feelings of envy and rivalry played out between the three girls, especially when the two younger sisters were forced to wait for their elder sibling in clinic during sessions which took place in school holidays.

The waiting dynamics in relation to sibling relationships were being played out in a powerful way inside the clinic. As I waved goodbye to these patients, I came to wonder what their parents were noticing at home and how it was really affecting the family dynamics. In this way, the research topic was finally formulated.

1.4: Possible outcomes of the study

In her paper entitled: *Developing Qualitative Research Questions: A Reflective Process*, Jane Agee (2009) writes: ‘When beginning to write questions, a researcher might use the old, but useful question, ‘So what?’ What difference will this inquiry make in the field of study in which a researcher is working?’ I have thought about this deeply and come to the conclusion that this ‘So what?’ is a question with a potentially purposeful answer in the study I am proposing and therefore worth researching.

I am interested in whether the data I collect in the course of my research could make a case for triaging siblings on CAMHS waiting lists given that most have endured similar experiences – usually profound adverse childhood experiences (ACEs) – and are living in the same family systems.

Currently, children and young people in the catchment area of my own CAMHS service can, in the first instance, self-refer or be referred by parents, schools, social workers, hospitals or GPs to a lower-tier counselling service. This is a long-established local charity offering emotional wellbeing advice and support to children and young people. If this single point of access (SPA) concludes that CAMHS input is required, it can refer the young person to our more specialised, Tier 3 service.

All referrals received are triaged by CAMHS clinicians and depending on risk and other factors, a young person can be accepted or declined by CAMHS. If risk is very high, a young person could be accepted to the Adolescent Team. If they have a diagnosis indicating neurodiversity, they can be accepted by the Neuro Team. If they are a looked after or adopted child, they can be accepted by the Looked After Children (LAC) team. If CAMHS is indicated but risk is low, they can be directed to the Generic Team. However, within this

process, no particular consideration is given to the relationship of siblings and its meaning in the context of service provision.

Referrals are triaged every day except for weekends. During triage meetings, clinicians decide if a young person can be accepted, declined or prioritised due to risk and circumstances. Triage is currently based on current risk and circumstances with no special consideration given to siblings living in the same household. This is in contrast to the UK education system which – while of course not comparable to CAMHS in its purpose (although some teachers may argue vehemently that there are increasing overlaps) – does appear to hold siblings in mind in its institutional dynamics. Most admissions criteria give priority to children who already have siblings in school – indicating a recognition of a need for continued shared experiences in this unique dynamic.

In developing this study, it became increasingly important to move from a more general statement of interest towards a clearer articulation of the research questions guiding the inquiry. The study is therefore concerned with the following questions:

- How do parents understand and make sense of the impact of CAMHS-based psychoanalytic psychotherapy on relationships between siblings?
- What is the experience of sibling relationships when one child is in treatment and another remains on the waiting list?
- How might differences in access to therapeutic support be understood within the family dynamic?

A further consideration arises in relation to the nature of the data collected. While the focus of

the research is on sibling relationships, the accounts are drawn from parents rather than the siblings themselves. This introduces a tension between the object of the research and the perspective through which it is accessed. However, it is precisely this parental perspective that offers a particular vantage point on the emotional and relational life of the family, including dynamics that may not be readily articulated by children. This tension is therefore not viewed as a limitation alone, but as something to be thought about within the interpretative frame of the study.

Chapter 2: Literature Review

This is a narrative literature review which offers an overview of the published research and a selected range of psychoanalytic psychotherapy literature concerning both siblings and the process of waiting for psychotherapy. I performed a systematic literature search on the specific subject of the thesis but – at the point of submission - I was unable to find any writing on the specific topic of siblings who wait for one another in clinical settings. The resulting review was ultimately compiled through comprehensive searches on both siblings and the process of waiting. It reflects on the history of siblings within the canon of psychoanalysis and addresses the factors which shape their identity and ensuing dynamics.

2.1. Search Strategy

I conducted a literature search using bibliographic databases, employing appropriate search strategies using Boolean operations of nesting and truncation. The database was hosted via EBSCOhost and included PsychoINFO. The Pep Archive was also used, which includes psychoanalytic journals. A search was conducted with the words ‘siblings OR brother OR sister’ and ‘psychoanalysis OR psychotherapy’. I also combined these searches with a new exploration employing the term ‘wait*’ and went on to undertake a basic Google search of books and manual research in high-street book shops. The search was performed in August 2023 to ensure the most recently published research was included within the timeline for this study. (See Appendix 12)

In undertaking this review, I was guided by the question of what is currently understood about sibling relationships within the context of psychoanalytic thinking and, more specifically, within experiences of waiting for therapeutic intervention.

The initial search generated a considerable volume of material. Even after applying PEP Archive Filters, the search results still produced a substantial 6564 suggestions of interest. Due to the lack of further filtering options on PEP Archive, I needed to sift through these manually, looking only for specific relevance to my topic. I needed to work accurately and efficiently, homing in on titles where the maximum number of key words were highlighted. Closer examination revealed that much of this literature did not directly engage with the particular constellation explored in this study.

The process of selecting texts was therefore both pragmatic and interpretative. Literature was included where it spoke meaningfully to either sibling dynamics or the experience of waiting, even where these had not previously been brought together. This inevitably shapes the argument that follows, privileging certain perspectives while leaving others aside.

The relative absence of directly relevant literature is itself striking. From a psychoanalytic perspective, this may be understood as indicative of a wider tendency to organise thinking around the patient in treatment, with less attention given to the siblings who exist alongside them. In this sense, the sibling may remain present but not fully seen or thought about, echoing dynamics that may also be present within both family life and institutional settings.

2.2. Key Definitions

I have referred to Chambers Dictionary for definitions of the two key terms featured in this study.

Sibling: *'A person who has a parent or an ancestor in common with oneself; a person who has both parents in common with oneself, a brother or sister.'*

Waiting: *'The act of remaining in expectation, delaying etc.'*

2.3. Key Themes: Siblings

2.3.1. A Key Writer Positions Siblings Centre Stage

Siblings are documented in key texts from the Bible to literary works such as Measure for Measure, Twelfth Night, Pride & Prejudice, Sense and Sensibility, To Kill a Mockingbird, Mill on the Floss and many more. However, according to one key academic they have been comparatively neglected in psychoanalytic writing and thinking. Juliet Mitchell, Professorial Research Associate in the Psychoanalysis Unit, UCL, said in an Internet YouTube video recording (2010):

'I had been studying hysteria...and there was something that wasn't explained for me...and one day...suddenly...the central thing [in psychoanalysis] is the Oedipus complex, like a big rock in the middle of the theory, and suddenly this rock sort of shifted slightly, and there were these dancing, squabbling children behind it. And...'Wait a minute, what are they doing?'

Mitchell explains that this lightbulb moment inspired her to both re-read her own notes and many other texts in which she found that ‘*siblings were just everywhere.*’ She later clarified her thoughts on this sense of revelation in a paper entitled: *Siblings: Thinking Theory*.

Mitchell said:

‘Looking back through the annals of psychoanalytic writings, they seem to have come up, been excitedly noticed with pleas for more exploration, and gone underground again. The good work has been dropped and later picked up once again rather than embraced and developed.’ (2013)

Mitchell’s own endeavours to develop psychoanalytic understanding of siblings are well documented. Her seminal work *Siblings: Sex and Violence* (2003), begins by reflecting on the often-taboo topic of sibling love, commenting:

‘The strenuous prohibitions on sibling love were internalized already by very small children but would themselves seem to have produced the psychic conditions so well described by psychoanalysis in relation to parents – the prohibition sets up repression which creates the desires as existing only unconsciously.’ (2003, Preface p. xii)

For Mitchell, siblings present an opportunity for psychoanalysis: ‘*Looking at siblings is looking anew at sex and violence. Bringing in siblings changes the picture we are looking at.*’ (Mitchell 2003, Preface xvi). She explains how they came to her as a revelation in the late 1990s after spending many years pondering the idea that something was missing in her understanding of hysteria. Freud, she reflected, had focussed on the vertical axis of the

Oedipal complex, arguing that: *'in order to marry our wife we need to know in childhood that we cannot marry our mother (the Oedipus complex)'* (p.2). Later psychoanalytic theory, particularly Object Relations theory continued to focus on this axis but elaborated more on the mother-infant dyad, the pre-oedipal dynamic. Without seeking to underestimate the importance of this vertical-parental axis, Mitchell (2003) began to question what had been lost in overlooking siblings and their 'heirs' on the horizontal axis. She wrote: *'I suggest that at the very least we also need to know we cannot marry our sister if we are to be able to marry our sister's (not just our mother's) psychological successor'* (p.2).

She describes the co-existence of powerful feelings of love and hate in sibling relationships where:

'...the adored sibling, who is loved with all the urgency of the child's narcissism, is also loathed as its replacement – the baby it can never again be, or the pre-existing older brother or sister that it will never be. The sibling is par excellence someone who threatens the subject's uniqueness. The ecstasy of loving one who is like oneself is experienced at the same time as the trauma of being annihilated by one who stands in one's place' (p.10).

Therefore – according to Mitchell - the child's wish is to annihilate the newborn rival, to make it disappear, and she contends that the possible resolution or mitigation of murderousness often means that rivalry can be seen as the solution to jealousy, rather than synonymous with envy. The rivalrous sibling's murderousness is channelled into aggressive play and healthy rivalry – a socially acceptable solution which can easily collapse into pathology. She convincingly argues that the mother, faced with the ferocious murderousness of the jealous, usurped older child, institutes what she describes as the 'law of the mother'.

The toddler wants to be rid of the baby who has taken its place and sense of uniqueness so the mother sanctions rivalrous play as a solution to potential murder. Mitchell postulates:

‘There is a fundamental desire to murder your sibling. It too meets a prohibition: you must not kill your brother Abel; you must instead love your brother (neighbour) as yourself. The violence must be turned into love’ (p.35).

Mitchell believes the ‘law of the mother’ is key because it must operate in order to intervene at the level of sibling murderousness and incest. According to her theory, even lone children are not exempt from the strong feelings of love and hate so prevalent in sibling relationships. In her most recent work: *Fratriarchy: The Sibling Trauma and the Law of the Mother* (Mitchell, 2023), she argues:

‘The ‘terrible twos’ of infancy have been underestimated – the notorious tantrums at this age are a trauma because the toddler is no longer allowed to be ‘itself’; the one and only baby of the family. The mother prohibits both its hating and loving reactions to the new baby. If there is no baby, then the violent response is to the thought of one, at the expected time’ (p.1).

Regardless of whether our brothers and sisters are real or imagined, Mitchell firmly believes:

‘The presence and memory of the richness of lateral relationships are an underestimated part of the fabric of psychic and social life.’ (p.171).

2.3.2. To Be or Not to Be Seen: A Sibling Spat in the Psychoanalytic Canon

Mitchell's bold contention that: '*Siblings have been given no autonomous place either in the theory or the therapy*' (2003 p.40) has caused consternation among psychoanalytic thinkers and therapists. Some agree with her, and others have leaped to the defence of its most significant forebearers Freud and Klein.

According to Mitchell (2003), Alfred Adler - who was particularly interested in birth order - was the only analyst to consider siblings seriously and extensively. She argued that Freud simply regarded sibling relationships as an extension of the Oedipal situation and points out that in *The Interpretation of Dreams* (1900-1) he remarked in passing that he had *never* encountered a woman patient who had *not* dreamt of murdering her sib - '*but he makes nothing of this.*' (2003 p.134)

She also cites Klein's *Narrative of a Child Analysis* (1961) as an example of the suppression of the sibling in the interest of the all-important mother. Klein's analysand Richard, who was evacuated to Pitlochry, Scotland, where his analysis took place in WW2, mentions his soldier brother Paul in the second session of his treatment. When Paul comes home on leave, it is clear to Richard that Paul is his mother's favourite son. Richard tells Klein how he both loves and hates the idea of his mother sending Paul chocolates, but Klein's interpretation of Richard's ambivalence does not mention Paul. And according to Mitchell (2003), Klein never makes an interpretation in which she is Paul in the transference despite her travelling to London in the Blitz and exposing herself to danger like Paul.

In the same year as her seminal thoughts were published, Mitchell found herself aligned with a literary sibling in the form of psychoanalytic psychotherapist Prophecy Coles and her book: *The Importance of Sibling Relationships in Psychoanalysis* (Coles, 2003).

In Coles' book, the very first paragraph poses the questions: '*Where have our siblings gone? Why do they not feature as significant figures in psychoanalytic accounts of the inner world?*' (p.1) and purports that: '*...there is a tendency in us all to wish that we could be the only child.*' (p.1). She argued that psychoanalytic theory had colluded with this desire and states that: '*Siblings are scarcely mentioned in the literature, and the concept of a sibling transference does not appear in any of the psychoanalytic dictionaries.*' (2003 p.2). She wonders if, in ignoring the place of siblings, psychoanalytic theory has acted out the fantasy of a jealous brother or sister hoping that rivals would disappear if ignored.

Like Mitchell, Coles is also interested in the limitations of Freud's Oedipus complex, believing that its centrality in psychic development is an oversimplification which banishes siblings from much-needed debate. She purports that: '*We need our siblings and peers to help us get away from our parents and teach us how to relate in a different way.*' (2003 p.2) and goes on to pose a central question in her theory: whether we fear the power of sibling relationships: '*Are they more passionate than parental relationships?*' (2003 p.2)

She is similarly dismissive of Freud's contribution to sibling thinking and laments how – in her opinion - psychoanalytic orthodoxy appears to have accepted his view that all sibling relationships are based upon primal hatred. She believes he instinctually understood the impact sibling relations had on emotional life, but his theoretical beliefs did not make room for them in the structure of the psyche. She contrasts this sense of siblings being underplayed with literary giants such as George Eliot and William Wordsworth who she points out

experienced deep passionate love for their siblings but have been 'ignored' by psychoanalytic theorists.

Coles makes the bold assertion that Freud conveniently omitted siblings from his central theories because of the importance he wanted to place on the Oedipus complex. She explains her position succinctly:

'If the wish to marry your mother and kill your father are the essential, unconscious wishes of the psyche, and from these wishes the structure of the psyche is determined, then it follows that an attachment to a sibling must be no more than a parental substitute.' (2003 p.30)

She goes on to take a closer look at Freud and his writings in a bid to shore up her central hypotheses. Autobiographically, she considers the loss of Freud's brother Julius aged 8 months in 1857 when Freud was under two and postulates that it was '*perhaps the most traumatic event that he suffered during his first three years.*' (2003 p.35) Coles suggests that Freud was not able to reflect on such a painful and confusing loss until he reached his sixth decade and wrote:

'When other children appear on the scene the Oedipus complex is enlarged into a family complex. This, with fresh support from the egoistic sense of injury, gives grounds for receiving the new brothers and sisters with repugnance and for unhesitatingly getting rid of them by a wish. It is even true that as a rule children are far readier to give verbal expression to these feelings of hate than to those arising from the parental complex. If a wish of this kind is fulfilled and the undesired addition to the family is removed again shortly afterwards by

death, we can discover from a later analysis what an important experience this death has been to the child.’ [1916-1917, pp.333-334] (2003: p.35)

Coles expresses her disappointment that Freud does not go on to elaborate on the experience of a surviving sibling, instead – she considers how ‘*he swiftly turns away*’ and in the next sentence adds:

‘A child who has been put into second place by the birth of a brother or sister, and who is now for the first time almost isolated from his mother, does not easily forgive her this loss of place; feelings which in an adult would be described as greatly embittered arise in him and are often the basis of permanent estrangement. [ibid.]’

In fact, Coles’ dismissal of Freud seems somewhat misguided. Freud *does* appear to be grappling with some profound thoughts in relation to the sibling psyche and it is interesting to think about his reflections in the context of the problematic ‘brotherly’ relationships he developed with fellow psychoanalytic thinkers such as Fleiss and Jung. At times, these friendships appeared variously loving yet rivalrous and ultimately ended in estrangement. Did he have these relationships in mind when thinking about siblings in later life? Coles’ conjecture that Freud is dodging an emotional bullet therefore seems somewhat unforgiving. However, she is clear in her own conviction that he does not give siblings the attention they deserve. For example, she concedes Freud’s consideration of The Wolfman’s sister in his life but only in relation to the role of the primal scene and subsequent Oedipus complex. Her seduction of her brother – Coles explains - is not considered part of his neurosis.

Coles is more forgiving overall and - in comparison to Mitchell - when it comes to Melanie Klein. She highlights the close relationship Klein had with her brother Emmanuel who she praised in her autobiography as *'the best friend I ever had.'* (Quoted in Grosskurth, 1985, p.39. Coles 2023 p.52). Coles credits Klein with restoring siblings to their rightful place in the inner world of the psyche through her belief that sibling love counterbalances the impulses of hate which Klein believes initiate the Oedipus conflict. According to Coles, this means: *'The envy and jealousy of the maternal breast can be repaired and the unbearable exclusion from the paternal bed can be mitigated.'* (2003 p.54)

Coles' own work specifically brings the idea of a sibling transference into play and laments its absence from analytic texts except where it is considered as a displaced Oedipal transference. She uses her own transference experiences as a therapist to reflect on how some patients have experienced her as a bossy, elder sister and also come to the conclusion that: *'an extremely harsh superego is often one of the hallmarks of sibling difficulties. Children can be extraordinarily cruel to each other.'* (2003 p.10)

For Coles, siblings can be internalized as figures of authority but do not appear to be given up or worked through in the same way psychoanalysts have come to expect from the Oedipal conflict. Moreover, she highlights the fact that in family systems where there are two siblings and a parent, it is the parent who can be positioned as the Oedipal rival to the siblings' relationship. Overall, she makes a clear and convincing case for the differences between the working through of classic oedipal and more complex sibling struggles:

'A child engaged in parental Oedipal struggles has two conflicting claims, to be the sole possessor of one parent and at the same time the wish to be loved and taken care of by

both parents. With siblings, the dynamics are different. Siblings have easier access to acting out their wishes and desires, whether hostile or loving, and this results in greater intensity of feeling which becomes less easy to relinquish.’ (2003 p.17)

Like Mitchell, Cole is resolute in her position that siblings have been left languishing for too long in the psychoanalytic shadows – and it took just over a decade for another group of respected writers to argue otherwise.

In 2014, Debbie Hindle & Susan Sherwin-White presented the psychoanalytic community with the publication of their book titled: *Sibling Matters: A Psychoanalytic, Developmental and Systemic Approach*. In some ways, this self-confessed ‘ambitious’ (2014 Foreword p.xvii) text reads like a heavyweight counterargument to Mitchell and Coles’ suggestion that siblings have been historically ignored by academics.

Sherwin-White appears agitated by Mitchell and Coles’ positioning of Freud as a sibling-denier. She refers to it as a ‘*strange misconception, on the part of both authors, that Freud himself neglected the importance of brothers and sisters in emotional development because of the Oedipus complex.*’ (2014 p.11) She points out that she taught Freud to Tavistock students for a decade and begins to make a strong case in his defence listing no less than 17 points under the heading: *Themes on brothers and sisters in Freud* (2014 p.13). Sherwin-White’s references range from the incestuous relations of brothers and sisters, through sibling jealousy to the replacement baby. She elaborates on each of her points in a convincing counterargument to Mitchell and Cole’s formulation, concretely pointing out that references to siblings appear throughout Freud’s work and are cited in 56 papers in the *Standard Edition*, spanning the years from 1893 – 1938.

Sherwin-White presents a similarly comprehensive defence of Klein's understanding of sibling dynamics in a dedicated chapter entitled: *Melanie Klein's thoughts on brothers and sisters* (2014 p.31). She explains that: 'Just as Freud's work on siblings has been unexplored and unrecognized, so has that of Melanie Klein.' (2014 p.31). This is despite her careful attention to the impact of a new baby, sibling rivalry, death-wishing and the role of siblings in emotional development and the Oedipus complex.

If Mitchell and Coles are the provocative siblings intent on triggering a family row with contrary thoughts, then Sherwin-White strides into the literary debate like a sensible parent wearing sturdy shoes. Her role is to re-orientate the reader to the reality of the psychoanalytic texts and evidence the finer detail within them. I think she succeeds, and the result is the undeniable conclusion that siblings might not always be centre stage, but they are not invisible.

2.3.3. The Shaping of Sibling Identity: Brothers, Sisters and the Development of Personality

Sibling Matters (Dunn 2014) is a comprehensive companion for clinicians interested in the brother/sister psyche. Judy Dunn opens the section on '*Developmental, Attachment and Systemic Perspectives*' by acknowledging the deficit in systematic research into sibling relationships. She laments that: '*In spite of the fact that 80 per cent of us have siblings, systematic research into the relationship has been relatively neglected, in comparison with the wealth of research on parent-child relationships*' (p.69).

However, Dunn makes commendable in-roads into redressing the balance by addressing some universal questions such as: *'Why do some siblings get along very well and others fight and argue continuously?'* (2014 p.76). She makes links between the quality of each child's attachment to its parents, citing evidence from Teti & Abard, 1989; and Volling & Belsky, 1992, that secure relationships with parents make for positive relationships between siblings. Meanwhile, she suggests that poor sibling relationships might be triggered by hostile, conflicted parental interactions. She highlights: *'It is sometime suggested that parents are modelling behaviour that their children then copy in their own sibling interactions.'* (2014 p.76). Based on what I have seen emerging in my own clinical work, this is certainly a connection which resonates and - in general – Dunn's contribution to the sibling canon is helpful in a straightforward way, less steeped in highbrow psychoanalytic theory and more grounded in clinical commonsense.

Alexander Kriss, Miriam and Howard Steele (2014) offer up further thoughts on sibling relationships through utilization of data from the longitudinal London Parent-Child Project (LPCP; see Steele & Steele, 2005a, 2005b). The LPCP was a mixed-method design which recruited 100 couples (first time pregnant women and their husbands/partners) in 1987 and followed them at multiple developmental points (prenatal, infancy, childhood, adolescence) to assess their attachment patterns.

In their chapter: *Sibling relationships: an attachment perspective* (2014 p.82) Kriss, Steele and Steele explain how they utilized data from the LPCP in an attempt to replicate previous sibling attachment data on a sample of early adolescents. They expanded this work by focussing on sibling relationship quality and further examining parent-child and sibling dyads using empirical and qualitative research methodology.

Looking through an attachment lens (Bowlby, 1969) at 30 mothers and fathers, 25 firstborn children and 30 second-born children, they found that it was – contrary to traditional thinking - *older* siblings who had developed a more secure attachment style than their younger brothers and sisters. They highlight how: ‘This goes against the traditional theoretical view that the older child is the most negatively impacted by the arrival of a sibling due to feelings of being usurped or replaced (e.g., Freud, 1919e; Mitchell 2003).

These researchers prove that one-size psychoanalytic theories should not be presumed to fit all, not matter how well-respected their authors. They discovered that because the siblings in their sample were similar but perceived themselves as being treated differently, the resulting relationships were highly competitive. They conclude that: ‘*when two children feel they are living in different worlds, their ability to understand each other beyond competitive or destructive impulses is impaired.*’ (2014 p.95)

As a researcher setting out on the path of sibling discovery, it could be tempting to view *Sibling Matters* as an oasis in an otherwise drought-ridden landscape. However, it is also important to consider the seminal work of American psychologists Stephen P. Bank & Michael D. Kahn which long pre-dates the debate between Mitchell/Coles and their contemporaries. However, it is no longer widely referenced – perhaps because it left print in 2008 - and I came to it later in my research journey by virtue of footnotes found in US journals.

Bank and Kahn in their work titled: *The Sibling Bond* (1982) boldly claim on the book cover page to be ‘*The first major account of the powerful emotional connections among brothers and sisters throughout life*’. This is likely to be true given that it predates Mitchell’s

controversial sibling lens which did not come into focus for another two decades. Like Mitchell, Bank & Kahn begin by lamenting the lack of attention given to siblings.

‘We had been taught that siblings are, at best, minor actors on the stage of human development, that their influence is supposed to be fleeting, and that it is the parents who principally determine one’s identity. The prevailing theories of human development seemed strangely silent about siblings and provided few conceptual principles or useful information to help us understand the emotionally charged, real-life dramas that were being enacted each day in our consulting rooms.’ (1982 p.5)

For researchers like me who are also steeped in day-to-day clinical practice with its many sibling permutations, Bank & Kahn make a salient point. There is a little sibling food for thought in trainings schools, supervision or widely disseminated reading material. It appears their publication was an attempt to bridge that gap, but it faded from mainstream reading lists and was only republished once more in an anniversary edition.

The authors explain how they accumulated 250 ‘*high interest sibling situations for careful study*’ mostly gleaned from their own patients over a decade (1982 p.17) and use the resulting material to compile a comprehensive examination of sibling processes. They make the salient point that: ‘*There can be no standard, unitary sibling bond*’ and that ‘*the permutations are endless*’ and challenge the therapist ‘*to find out the nature of each sibling bond, whether it is close or distant, and how it was forged.*’ (1982 p.296).

They reflect on their surprise at the start of their own research journey to discover how many ‘*highly charged*’ sibling experiences their patients had had (including incest, suicide,

abandonment, psychotic episodes and caregiving) that were never touched upon by their therapists. The resulting text examines the influence of childhood intimacy, parental behaviour, family turmoil, birth order, and gender.

Like Mitchell, who took up the baton many years after them, Bank & Kahn also hold Freud to account for allegedly never using '*sibling-specific concepts*.' We have seen how this idea has been contested and somewhat disproved by later contemporaries loyal to Freud, but I think there is another point which Bank & Kahn make which is uniquely valid and clear:

'The vertical parent-to-child vector is so deeply embedded in dynamic theory that master therapists ignore the parallel, peer-related horizontal vectors of sibling-to-sibling relationships and instruct the next generation therapists in the same manner.' (1982 p.299)

They consider specific sibling transference reactions such as when: '*The patient who has an aggressive, compulsive need to compete with the therapist, has often received the brunt of a destructive siblings' tyranny.*' (1982 p.304)

And surmise that for some patients:

'The therapist qua sibling is someone they too often try and look after, relinquishing their own needs in a session, bringing him gifts, showing premature progress, asking the therapist how he feels, accommodating themselves in the session to whatever topic he wants to bring up, and subordinating their own moods and needs to those of the therapist so far as they can intuit them.' (1982 p.304)

2.3.4. The Horizontal Couch: Sibling Thinking in the Transference

Bank & Kahn's thinking about transference led me to research other academics who had recognised the same phenomenon in their work.

Jeanine M. Vivona wrote a paper called *Sibling Recognition and the Development of Identity: Intersubjective Consequences of Sibling Differentiation in the Sister Relationship* (2013) in which she omits Bank & Kahn's contribution and credits the more ubiquitous Juliet Mitchell (2003) with 'giving us a place from which to develop our understanding of sibling relationships and dynamics.' (Vivona 2013 p.2)

Vivona goes on to describe clinical vignettes which – in her view – provide clear evidence of sibling transference when taken up as such. She describes 'sisterly struggles' with one patient which reflected the patient's dynamic with her own sibling, who she perceived as the paragon of perfection. Vivona explains:

'Like Mitchell, I found that once I began to envision the psychic landscape as comprising two dimensions, I saw the concerns of the lateral dimension lurking everywhere, including in important aspects of identity development and ongoing peer relationships.

'To understand identity fully, it turns out, we must consider the way one is positioned with respect to the siblings who are beside as well as to the parents who are above.' (2013 p.10)

Vivian Dent is another clinician who writes about Mitchell's influence on her clinical work. In her paper: *Reply to Commentary by Juliet Mitchell: Siblings in Clinical Work* (2009), she explains how Mitchell's work helped her to think about the countertransference in new ways. Dent reflects on how she was struck by the number of patients prone to paranoid reactions

who grew up with bullying or even brutal siblings. She also acknowledges how: *'Interpreting my role as that of an older sibling pretending to be a parent, whether out of insecurity or despotism, has proved quite useful.'* (2009 p.3)

Meanwhile, analyst Suzanne Haas-Lyon reflects on the machinations of her consulting room in which she says: *'I pay particular attention to sibling transference, which was characterized by intense envy, guilt and competitiveness and which involved negative therapeutic reaction.'* (2007 p.4) She suggests that *'when sibling relationships are pathogenic, the parental effect is probably large'* (ibid.) and considers sibling patients who convey a belief that the only possible positions available are *'in'* or *'out'*.

Haas-Lyon purports: *'The sibling who is 'in' feels superior and suffers from primary grandiosity, almost like royalty. However, guilt about doing better than her or his sibling and fears of her or his sibling's envy can make the 'in' sibling hold herself or himself back.'* (ibid.)

Finally, she considers how a parent incapable of genuine sexual intimacy may emotionally seduce a child into a spousal role as a safer and more dependable object than the actual spouse. Therefore, parental transference in regard to Oedipal sibling triangles can involve fear that the therapist could be seductive or rejecting, favouring or non-favouring.

In particular, I have found the reflections of these working clinicians helpful in relation to my own thinking about the patients I treat in CAMHS, many of whom originate from complex family systems in which parental input has been impeded for a variety of reasons. Their sibling relationships are often comprised of the various constellations which these writers allude to, and I am now more mindful and alert to these aspects of the transference.

2.3.5. Sibling Loss: The Concept of the Replacement Child

Siblings - it seems - are everywhere and nowhere in psychoanalytic thinking, ranging from some thinkers lamenting their erasure from the most prominent texts and theories to others evidencing their existence in every crevice of the consulting room. Themes of loss and replacement abound. For many families, there are real life experiences of loss and sometimes replacement which are central to the sibling psyche and eloquently captured by Leon Ansfield & Arnold Richards in their paper *The Replacement Child: Variations on a Theme in History and Psychoanalysis* (2000).

They define a replacement child as a child born to parents who have experienced the death of a child and then conceived a second child in order to fill the void left by the loss of the first. But they also remind readers of other configurations, including a dynamic set up when one sibling dies at an early age and another must fulfil the expectations the parents previously invested in their deceased offspring. Or adopted children who sometimes have to take the place of a biological child the parents were never able to conceive. And they allude to yet another permutation when there is a child in the family with a severe physical or mental handicap. In this case, they postulate that parental anxiety can take one of two forms, both of which pose damaging consequences for the remaining sibling:

‘The parents are either preoccupied with the sick child and in this way arouse in the healthy child depressing feelings of being neglected and slighted, or they concentrate on the healthy child, pushing him to succeed and forcing him to strive for achievements, so that he

might compensate for the inability of the sick child and so alleviate the parents' feelings of failure.' (2000 p.2)

Ansfield & Richards consider the psychic position of the replacement child, suggesting that: 'If there has been only a 'pseudo resolution of mourning' the child who has been put in the place of someone else will necessarily only have a 'pseudo identity'. (2000 p.8). They quote Andrea Sabbadini's (1988) observation that the replacement or substitute child 'is treated more as the embodiment of a memory than as a person in its own right.'

These authors also poignantly consider the plight of replacement siblings through the lens of the '*collective tragedy*' of the Holocaust. For them, it gives the replacement child concept special meaning '*since the children born in its aftermath had to fill the void in the lives not only of individual parents but of the Jewish people as a whole.*' (2000 p.1) While I am not aware of any of the participant families in my own research being of Jewish heritage, I have found the thinking in this paper immensely helpful. It particularly highlights the dynamic between siblings where one is initially prioritised for treatment over another and perhaps considered to be more unwell or consistently viewed through a mental health lens within the family constellation.

Finally, I would like to give the last word in this overall section on siblings to the child psychotherapist Margaret Rustin who achieves the impressive feat of presenting an astutely comprehensive overview in a single paper entitled: *Taking account of siblings: a view from child psychotherapy* (2007). She takes the view that '*Clinical experience with children repeatedly reveals the vital significance of real, lost and imagined siblings.*' (2007 p.2)

For Rustin, the existence of siblings is innate, a preconception (in Bion's terminology, 1962) awaiting its realisation. She explains: '*They are always present in the mind, whether existing in external reality or not.*' (2007 p.10)

And she adds new thinking to the subject overall, introducing a sociological dimension which includes the prediction that siblings will become even more important characters in our lives as maternal employment outside the home increases and brothers and sisters become more reliant on one another for both practical and emotional support. And at the other end of the life spectrum, she highlights how they are once again significant figures with whom we will increasingly share the emotional and financial burdens of caring for parents who are living longer. Rustin does not concur with Mitchell's idea that siblings were historically in the shadows and seems certain that the future will place them more centre stage than ever before.

2.4. Key Themes: Waiting

Despite an extensive database search, I could not find any research or writings dedicated to siblings who wait for one another in health care settings. In general, there appeared to be a deficit of thinking in relation to children's perspectives of waiting for treatment. My aim was not to cover a full bibliography on the topic of waiting but rather to find subject matter most closely aligned to the experience of waiting in clinical settings. In lieu of material specific to my thesis title, I have explored three papers which address the concept of waiting for health care in different guises.

2.4.1. Waiting in the National Health Service (NHS)

The art of medicine: A waiting crisis? (Salisbury et al: 2023) shines an interesting light on the NHS in a period of recovery from the COVID-19 pandemic and ‘*what is being characterised as the biggest crisis of waiting since the inception of the NHS.*’ (2023 p.1) The authors make the salient point that waiting is not care’s opposite but instead, intrinsic to it – existing in the time needed to assess a number of interventions including therapy, diagnosis and long-term treatment monitoring. They reveal how their collaboration: *Waiting Times – a Wellcome Trust-funded research project on the relationship between time and health care* (Salisbury & Baraitser, 2017) – has found that practices of slowing time are vital to care.

The authors postulate that “waiting is intrinsic to care” (2023 p.1) because: “It is there in the extended time needed for therapy or therapeutics to work; in the watchful waiting before or after diagnosis; and in the time that stretches through remission, relapse, or palliative care.” (2023, p.1) And yet they also concede that clinicians in the UK’s child and adolescent mental health services (CAMHS) are faced with increasing referrals and thus must try to find ways to mitigate crisis and manage parents’ concerns.

NHS-specific waiting is examined in more depth and there is an interesting historical point made about how its inception in 1948 introduced a culture of waiting tolerance due to patients being grateful for and proud of a system of universal care: ‘*Waiting had a place as a collective practice within a shared, social project.*’ (2023 p.1) However, the 1980s brought new managerial cultures and political aims which re-positioned waiting as service failure.

Another interesting point made by these authors is the fact that: ‘*the tolerability of waiting is determined not so much by the quantity of time one is asked to endure, but its quality.*’ (2023

p.1) As this essay suggests: *'Being prepared to wait requires tolerating uncertainty'* (2023 p.2) and sometimes, for young people in crisis, this is perhaps too much to bear.

Sophie Day (2016) also homes in on the NHS in her essay *Waiting and the Architecture of Care* and rightly points out: *'The NHS wait is visible to all and is one of the most prominent topics of complaint.'* Unlike the previous essay's more positive formulation of slowing time, Day thinks that: *'For the supplicant, waiting is dead time, a form of entrapment that accentuates inferiority and steals away your life.'* (2016 p.168) Certainly, a few hours spent in any busy NHS setting seems to give credence to this idea, with an increasing number of signs asking patients to be courteous to staff and refrain from violence.

However, she makes another interesting point, presenting waiting as a type of defence against pain:

'For patients, waiting often served as a cover term for their problems, and it also carried a sense of expectation, an orientation toward the impossible fantasy of finding someone who would take responsibility for your care and prevent or solve these problems in the future, a person who might also be thinking about you in between visits.' (2016 p.170)

2.4.2. Parents Who Wait with Children

CAMHS clinician's rightly train their gaze on children who line the columns of their treatment lists but what is the experience of the *parents* who wait alongside their offspring? Wendy Carolyn Woodhouse, a counselling psychologist, explores this in her thesis entitled:

An Investigation into the Waiting List Experience: Exploring Parents' Views of Children Referred to a Child & Adolescent Mental Health Service (2006).

She conducted a qualitative research project, and she interviewed 6 parents whose children were on the waiting list at the Child and Family service in her clinic. The dialogues revealed mothers and fathers struggling to understand what is wrong with their child and what they can do to help.

Woodhouse states: *'The daily difficulties appeared to be perpetuated by the lack of communication from the service to which their child had been referred. Parents seem to wonder where they went wrong as a parent and feel they are to blame as a result of their child needing to be referred to a Child and Adolescent Mental Health Service.'* (2006 p.70)

Woodhouse uncovered a feeling of loneliness among the parents she interviewed. She adds: *'Within this latter state they seem to feel that others do not understand or appreciate the difficulties with which they have to contend. As the waiting time continues the silence from the services appears to deepen the loneliness.'* (2006 p.70)

Unsurprisingly, five of Woodhouse's six interviewees stated that the waiting experience had caused stress within the family. They described feeling more disempowered and out of control as the waiting time continued and it was this position of disempowerment which prevented them from challenging the system into which they had been referred. This dynamic was exacerbated by limited knowledge of the referral system. Without a professionally-endorsed reason for their child's behaviour, it seems the parent feels there is no alternative but to blame themselves and this subsequently deepens the experience of loneliness and abandonment.

2.4.3. Young People Who Wait

Punton et al (2022), of the University of Northumbria's Department of Psychology, present some interesting findings in their interpretive phenomenological analysis of young adults' experiences of waiting lists within mental health services in the UK. Called 'You're on the waiting list', it interviewed 7 young adults aged 19-22. The participants reported a variety of negative consequences associated with their experiences, including exacerbated physical and mental health issues.

The researchers found that one of the more common experiences was heightened anxiety and stress levels due to the uncertainty surrounding the delay and its length. Additionally, participants stated that their worsening symptoms were due to perceptions of the services not believing their issues were severe enough to be seen sooner. Young people also reported the emergence of negative beliefs, emotions and thoughts during the waiting period, including feelings of anger and hopelessness.

CONCLUSION

Overall, the process of researching literature on siblings left me feeling perplexed by the comparative absence of the sibling relationship in psychoanalytic writing and thinking – as opposed to that of the parent-infant dyad. The sibling relationship is one of the most enduring of any lifetime – so how and why were brothers and sisters being neglected?

As someone working in a full-time NHS CAMHS setting, I was continually seeing different permutations of sibling dynamics in the clinic – in both the consulting and waiting rooms – but I could not see these important relationships widely reflected in the literature.

In the early stages of researching literature, I found only two writers in particular prominently championing the cause of siblings – Juliette Mitchell and Prophecy Coles. Further reading of Mitchell left me in agreement with her statement that: “*Bringing in siblings changes the picture we are looking at.*” (Mitchell 2003, Preface xvi).

Indeed, her work began to shed new light on how some child mental health formulations could be constructed with deeper insight when considering dynamics such as the co-existence of powerful feelings of love and hate in sibling relationships and the presence of a sibling transference in relation to the therapist. In my view, lateral relationships appeared to be a vastly underestimated part of CAMHS life and perhaps – as some of the authors I researched postulated - wider psychoanalytic thinking in general.

The more I learned about siblings largely hidden position in psychoanalysis and clinical research, the more this knowledge guided me in formulating a research study and question which would bring them back into full view. I had first hand clinical experience of the painful

dynamics which played out when one sibling was in treatment, and another was waiting but I was keen to explore all this in more depth. I formulated the title of my research project: 'Ghosts in the Waiting Room' as a way of trying to capture the sense of the sibling as someone who is always there yet in the shadows. Present in important relationships and yet somehow absent in wider thinking.

Continued reading helped me to understand that there is no standard sibling bond. Instead, the permutations are endless, and each sibling dyad should be considered as a separate entity in its own right. However, it was particularly interesting to read about the impact which different parental relationships could have on siblings and how being treated differently could result in highly competitive dynamics. I was keen to explore this further as part of my own research question. How would it impact the sibling relationship if one reached a CAMHS therapist for desperately needed treatment before the other, who was forced to wait?

Chapter 3: Methodology

This section explains the aims and objectives, the rationale of the chosen method, describes participants recruitment, data collection, analysis and the ethical considerations of this study.

3.1 Aims and Objectives

The primary aim of this study is to explore how parents understand and make sense of the impact of CAMHS-based psychoanalytic psychotherapy on the relationships between biological siblings when one child is in treatment and others remain on the waiting list.

This aim reflects the phenomenological focus of Interpretative Phenomenological Analysis (IPA) on exploring lived experience from the perspective of those directly involved, while recognising the interpretative role of the researcher in making sense of participants' accounts.

In keeping with IPA's idiographic ethos, the study seeks to examine in depth the nuanced, individual perspectives of each participant before identifying patterns of convergence and divergence across cases. The research is not intended to generate generalisable claims but to provide a detailed, interpretative account that illuminates how such experiences are understood within specific familial and service-related contexts.

More specific objectives include eliciting rich, detailed accounts from parents regarding their perceptions of sibling relationships in the context of one child receiving psychoanalytic psychotherapy and others awaiting treatment.

The study also aims to identify and analyse experiential statements (previously known as emergent themes in IPA) that capture parents' interpretations of changes, challenges, and continuities within sibling relationships during this period.

Following IPA rationale and guidelines, it attempts to interpret these statements in the context of participants' personal and familial settings alongside the broader CAMHS service contexts, attending to both shared and unique elements of experience.

Finally, the study aims to critically reflect on the researcher's role in the interpretative process, acknowledging the co-construction of meaning between participant and researcher.

3.2. Study Design: A Qualitative Approach

The study employed a cross-sectional qualitative research design.

In psychotherapy research, a variety of qualitative methods are used, ranging from thematic analysis (TA), narrative analysis and interpretative phenomenological analysis (IPA). This study is a small-scale qualitative professional research doctorate within a psychoanalytic psychotherapy training. The method chosen to investigate the topic is IPA designed by Smith & Osborn (2003), Smith et al (2022).

3.3. Interpretative Phenomenological Analysis (IPA)

Jonathan Smith, a British Professor of Psychology, developed IPA as a qualitative research method designed to capture the experiential. He has described it as an approach: '*committed to the examination of how people make sense of their major life experiences.*' (Smith et al 2022 p.1). Because it involves this detailed examination of the participant's experience, it is considered to have a phenomenological origin.

Phenomenology was first developed by philosopher Edmund Husserl (1931) who wanted to understand the context and meaning of 'lived experiences' and famously urged phenomenologists to go '*back to the things themselves*' (Smith et al p.1). This grounding in lived experience makes it well-suited to psychoanalytic psychotherapy and its interest in both conscious and unconscious meanings.

IPA's developers suggest that when people are engaged with 'an experience' of something major in their lives, they begin to reflect on the significance of what is happening, and IPA research aims to engage with these reflections. It also allows participants to explore their own narrative without preconceptions of the content. It has the advantage of allowing an in-depth and detailed study of phenomena that is not easily quantifiable. The IPA authors state:

'This attempt by the research participant to make sense of what is happening to them takes us to IPA's second major theoretical axis. It is an interpretative endeavour and is

therefore informed by hermeneutics, the theory of interpretation. IPA shares the view that human beings are sense-making creatures, and therefore the account which participants provide will reflect their attempts to make sense of their experience.' (Smith et al p. 3)

IPA therefore provides a pragmatic and accessible approach to qualitative research that can be used in clinical settings such as the UK's Child & Adolescent Mental Health Service (CAMHS). Examining how people make sense of major life experiences is consistent with the research aims of this study and: *'It can be said that the IPA researcher is engaged in a double hermeneutic because the researcher is trying to make sense of the participant trying to make sense of what is happening to them.'* (Smith et al. p.3)

In this study, participants shared their knowledge and experience of their children's (specifically siblings') sense of having to wait for treatment while another was receiving it. There was, therefore, a triangulation between the researcher, the participant and the siblings' experiences as understood by the participants.

IPA started in psychology and has been picked up particularly strongly in clinical and counselling fields as well as in social and educational psychology. It has been used to explore a range of mental health difficulties including eating disorders, ADHD and depression. For example, it was used in the Anna Freud Long-Term Follow-Up Study, which offers a unique look at the lives of 34 adults who received psychoanalytic psychotherapy in childhood.

The study provides a life-span perspective on the adult outcome of childhood disorders going far beyond the usual short-term time frame of most follow-up studies (Eyberg, Edwards, Foote & Boggs 1998 in Midgely et al 2009).

IPA was employed to qualitatively explore subjects' recollections and understandings of the treatment they received in childhood and the ways in which they felt the treatment impacted on their current lives. Researchers were also using IPA *'to look beyond the subjects' conscious beliefs about their life experiences to identify ways in which they had integrated their experiences of childhood disorders and child psychoanalysis into their experiences of themselves and their life stories.'* (Midgely et al 2009 p.154)

3.4. Why Not a Different Qualitative Method?

IPA was chosen over grounded theory (Glaser & Strauss 1999) as the latter might be considered more of a sociological approach (Willig 2003). It was one of the first formally identified methods for qualitative researchers and generally sets out to generate a theoretical-level account of a particular phenomenon. This often requires work of a considerable scale and the topic for a grounded theory study need not be psychological. According to Smith et al (2022): *'Grounded theory is likely to be attractive to you if you have the time and space to deal with a lot of data, if your focus is not necessarily (or primarily) psychological, if you are keen to have a relatively structured protocol to follow, and if you wish to move to quite a high-level conceptual account.'* (p38). IPA, with its focus on psychological phenomenon and being concerned with providing more detailed and nuanced accounts of personal experiences within a smaller sample group appeared to be a better fit for this study.

Discourse analysis (Jorgensen & Phillips 2002) was also ruled out because it is sceptical about the accessibility of cognitions and focusses on language more in terms of its function in constructing social reality. While IPA recognises that cognitions are not transparently available from verbal reports, it engages with the analytic process in the hope of being able to

say something about the sense of meaning involved in this type of thinking akin to psychoanalytic psychotherapy.

There are certainly other research methods which provide tools for analysing data in a functional way, but IPA is best suited to focusing on the phenomenological aspect and '*can tell us something about people's involvement in and orientation towards the world, and/or about how they make sense of this.*' (Smith et al. 2022 p. 41). It also aims to avoid premature generalisations about populations. In this study, I have endeavoured to capture the voices of participants, their individual experiences and the complexities in the relationships between siblings when one is in treatment, and one is waiting.

3.5. IPA and Psychoanalytic Thinking

This study sits at an intersection between psychoanalytic thinking and Interpretative Phenomenological Analysis (IPA), and it is important to reflect on the relationship between these approaches. While both are concerned with meaning and subjective experience, they do not align seamlessly.

IPA is grounded in a phenomenological commitment to understanding how individuals make sense of their lived experience, while psychoanalysis extends beyond this into consideration of unconscious processes and meanings that may not be immediately available to conscious reflection. This introduces a potential tension between staying close to the participant's account and engaging in a deeper level of interpretation.

In this study, I have attempted to hold both positions in mind. IPA provides the

methodological structure through which participants' accounts are explored in detail, while psychoanalytic thinking informs a more interpretative engagement with the material. This requires a careful and reflexive stance, in which interpretations are grounded in the data while remaining open to meanings that may not be explicitly stated.

As previously mentioned, approaches such as Grounded Theory and Reflexive Thematic Analysis were reflected upon. While these may have offered valuable ways of organising the data, IPA was ultimately chosen for its emphasis on depth, idiography and the interpretative relationship between participant and researcher, which felt most closely aligned with the aims of this study.

3.6. Participants

A reasonably sized sample of 4 participants who have experienced parenting siblings who are in treatment in a CAMHS service while another, related sibling, waits, took part in the study. The sample size is considered a reasonable number for an IPA doctoral research study (Smith et al. 2022). One of IPA's requirements is to have a small and reasonably homogenous sample, so all participants were the sole carers of the siblings and had experience of consistently bringing them into a CAMHS setting.

The participants included both biological parents and kinship carers who are referred to as caregivers. In all instances, it is the person with whom the child principally resides who is referred to as the parent or caregiver and was interviewed for the purposes of this study.

3.6.1. Inclusion and Exclusion Criteria

In order to train the clearest and most accurate lens on the sibling dynamic posed by my research question, I built inclusion criteria into the recruitment process.

The inclusion criteria included:

- Parents/caregivers of children who have experienced one sibling in psychoanalytic child psychotherapy treatment for at least one year and one sibling who has waited for treatment or access to treatment for the duration of that period.
- The parent/ caregiver interviewed will be the parent/caregiver who has been primarily responsible for supporting the CAMHS treatment – for example bringing their child to CAMHS, remaining in the waiting room during sessions and attending psychotherapy reviews.
- Siblings must be biologically related.

Conversely, an exclusion criterion included:

- Parents who do not meet the inclusion criteria.
- Parents who have not been regularly involved in the CAMHS treatment process.
- Siblings who are not biologically related.
- Siblings who are disabled, including neurodiverse (to rule out an area of sibling relationships which appears to be well-documented and researched).

3.6.2. Sample

The sample is made up of the following participants (pseudonyms have been used in all cases):

- Biological parent Sarah is a white British mother of two. Her children are Adrian, a 16-year-old trans male with a diagnosis of ASC and Michelle, aged 12. The family suffered a significant trauma after their father, Sarah's husband committed suicide. Adrian was referred to CAMHS after expressing suicidal ideation and entered psychotherapy treatment. Michelle remained on the waiting list in a lower tier service.
- Kinship carer Melissa is black British. She took on the responsibility of caring for her nephew Kevin, 13, and Sarina, 11, after their mother (her sister) could no longer care for them. The siblings experienced domestic violence and the deaths of their father and maternal grandmother. Melissa juggles this role with caring for her own teenage biological children. Kevin entered CAMHS psychotherapy treatment while Melissa remained on the waiting list.
- Veronica is the white British biological mother of Jools, an 18-year-old trans male, and Laura, aged 16. Jools entered CAMHS following a diagnosis of anorexia and ASC. His sister was waiting for treatment when she took an overdose in a bid to speed up the process of being seen.
- Belinda is a white British mother of two who also parents her sister's daughters Davina, 13, Sarah, 8, and Rebecca, 7, in a kinship agreement. Her sister continues to

struggle with drug addiction. At the time of interview, Sarah was having psychotherapy treatment in CAMHS and Davina was waiting to be admitted.

3.6.3. The Study Setting: The Context of the CAMHS Clinic

All participants were recruited from one CAMHS service. The National Health Service (NHS) clinic provides CAMHS assessments and treatment for children aged between 0 and 18. The clinic is made up of the following teams: Generic, Adolescent, Looked After Children, Neurodevelopmental. The teams are multi-disciplinary and include psychiatrists, clinical psychologists, occupational therapists, specialist mental health nurses, social workers and child psychotherapists. There are trainees embedded in all disciplines.

The clinic is based in an outer-London location, in a borough with a population of over 300,000 (2021 census). Referrals come from a variety of sources including social workers, teachers, GPs and lower-tier counselling services.

3.6.4. Recruitment Process

In order to identify potential participants, I first composed an email outlining my research aims (see Appendix 1) and sent it to my CAMHS colleagues. I also designed a small leaflet and communicated this in a more visual form (see Appendix 2). Finally, I mentioned my research project in a team meeting. Ultimately, it was the process of both handing out and discussing the leaflet which elicited the most fruitful outcome and colleagues from both the Generic and Looked After Children teams facilitated introductions with 4 participants who fulfilled the inclusion criteria.

I provided the participants with copies of the Research Project Information Sheet (see Appendix 3) and a summary of the research protocol. They were offered a ‘cooling off period’ to consider whether or not to take part but all 4 responded swiftly, consenting to cooperate and I was delighted to interview what amounted to a fascinating sample.

Participants were offered a choice of being interviewed online or meeting in the clinic. Ultimately, 3 interviews were conducted online and 1 took place in the clinic.

3.7. Data Collection

I developed a semi-structured interview schedule (see Appendix 4) which was informed by relevant literature, discussions with my supervisor and Smith et al.’s (2022) guidance on interview development through published guidelines. It was used flexibly but consistently to ensure that all participants had a non-led experience. The interviews aimed to elicit rich, detailed data from the participants’ accounts of parenting siblings who had experiences of waiting for treatment while another’s had commenced. They lasted between 37 and 54 minutes and were recorded and automatically transcribed using Otter.ai technology.

3.8. Ethical Considerations

This research adhered to the guidance provided by the Code of Professional Conduct and Ethics (Association of Child Psychotherapists 2017). The proposal was discussed and agreed with both my CAMHS clinical supervisor and manager. It was also approved by the relevant NHS trust’s quality and governance department, and research leads at the Tavistock and

Portman NHS Foundation Trust (see Appendix 5 for TREC approval letter). No ethical dilemmas were raised.

3.9.1. Consent

I sought written consent from 3 separate bodies: the CAMHS clinic manager, the relevant Trust's quality and governance department and my sponsor – the Tavistock and Portman NHS Foundation Trust via a TREC form and related ethics panel approval.

All participants were provided with information about consent as part of the Research Project Information Sheet (see Appendix 3), which clearly sets out information about the study, including the purpose of the research, necessary involvement from participants and access to and storage of data. The information sheet was used as the format for an invitation to take part so potential participants could take as long as they liked/needed to consider the contents before deciding to contact me.

Before the interview took place, I made sure participants had read and understood the contents of the information sheet and gave them an opportunity to ask further questions before formally committing to the process. Additionally, they were given the consent form to read (see Appendix 6) and asked to give written consent before being interviewed. A signed copy of the consent form was given to the participants, and a second copy was placed in the research file. Participants were also informed that there was a period of two weeks post consent where they could withdraw from the study without needing to give an explanation. There were no withdrawals.

3.9.2. Confidentiality

Participants were fully informed about confidentiality and its limits. They were made aware that their interviews would be transcribed but any identifying markers would be removed. However, given the small sample, it was made clear that some quotes might still be identifiable. They were informed that my research supervisors would be given access to the anonymised transcripts if requested. To retain confidentiality, all details regarding the location of the clinic have been omitted in the appendices.

3.9.3. Data Storage

Interview transcripts were stored securely in a password protected file. As suggested by the relevant Trust's quality and governance department, I was mindful of refraining from gathering unnecessary information and ensured any identifiable data was anonymised.

3.9.4. Data Analysis

Semi-structured interviews were analysed using IPA methodology (Smith et al. 2022). The analysis of the data was informed by the qualitative research guidelines which endeavour to ensure quality (Spencer et al. 2022). As stated above, the interviews were both recorded and transcribed using Otter.ai technology. I listened to the audio recordings numerous times and checked the transcriptions for accuracy against them.

I also kept a reflective diary and wrote down my initial thoughts, feelings and reflections upon hearing the recordings played back. I found this a helpful way of staying aligned with the IPA principle that ‘the end result is always the result of how the *analyst* makes sense of how the *participant* makes sense.’ (Smith et al. 2022 p. 77) It was remarkable to consider how I was struck by subtle aspects of the dialogue such as a change in vocal intonation, rhythm, repeated use of particular words or the use of a breath/pause. Some of these elements had stayed in my mind after the original interview encounters and others were revealed and highlighted afresh in this playback process.

Following this process, the transcriptions were read 3 or 4 times before I began to underline the text. I initially devised a crude paper template with a margin either side of the main text: one margin for descriptive exploratory comments highlighting initial thoughts about the content, the use of language and any arising concepts. The other margin was used to note experiential statements, drawing on both the transcript and the initial analysis (Smith et al. 2022). I later transferred the paper system to online tables for ease of comparison and manoeuvrability.

Smith et al. (2022) advise researchers to define which experimental features the coding explores. In my data analysis, I focused on descriptive exploratory and linguistic markings to gain an understanding of each participant.

According to Smith et al. (2022), there are two major facets of IPA data analysis to consider: first, to develop a descriptive account of the experience of participants and second, to move from descriptive interpretation to explore the meaning participants give to aspects of their

stories. This clear guidance ultimately proved helpful in writing the findings and discussion chapters and developing emergent themes.

To begin with, I analysed each transcript individually and in-depth before creating a Word document and placing the transcript at the centre of the page, with a column on either side. The column on the right contained my exploratory notes, and the column on the left supported the experiential statements. (See Appendix 7 for an example of this stage of the analysis).

I worked through each transcript, line by line with as much precision as possible, first capturing the exploratory notes. They included all my thoughts, ideas, comments and questions about the text. I spent a lot of time finely combing through each transcript, building ideas about what I felt was going on for the participant in the interview process.

Next, I began formulating experiential statements: pithy interpretative summaries of what I felt was happening in a specific portion of text. I typed and printed them out before cutting them up so I could physically move them around and try to create groupings. As per the guidance from Smith et al (2002) I was looking for connections; ways in which the statements spoke to each other, came together or contrasted with each other. (See Appendix 8, 9 & 10 for examples of this process).

This clustering process allowed me to move to the next step of defining the personal experiential themes (PETs) and building a table of them for each participant (See Appendix 11 for an example). Smith et al. (2002) explain how PETs are: '*Personal* because they are at the level of the person. *Experiential* because they relate directly to the participant's

experiences,’ and ‘*Themes* because they are now no longer tied to specific and local instances within the transcript (as statements are). Instead, they reflect analytic entities present within the transcript as a whole.’ (p94, 2002). Within each PET, I added page numbers to connect each experiential statement to the transcript and quotes to make sure that the interpretations remained grounded in in the data.

Finally, I was able to move onto the cross-case analysis, looking across the different tables, and starting to think in terms of similarities and differences between people and/or threads and themes going across the group.

3.9.5 Validity and Quality

It should be noted that the participants’ experience of the siblings was shaped by those families attending CAMHS services in one particular Tier 3 NHS clinic, therefore children had a high level of need and complexity.

According to Smith et al. (2022): ‘*Validity is about assessing the extent to which the design and methodological approach used in a study are fit for purpose.....In addition, when we talk about quality here, we are trying to think about ways of identifying the relative merits of IPA studies which exceed the validity standards for ‘good enough’ research.*’ (2022: 147)

The authors go on to introduce Yardley’s (2000) four broad principles:

1. Sensitivity to context: I used the reflective diary to think about the setting and my pre-existing relationship to the clinic. I was aware of my dual role as both a child

psychotherapy trainee and researcher – and aspects of transference in relation to the clinic and individual practitioners. Meanwhile, I endeavoured to approach my interactions with the participants from a standpoint of genuine curiosity and interest, paying particular attention to ethical issues during all phases of study.

2. **Commitment and rigour:** Yardley (2000) defines commitment as both in-depth engagement with the topic and developing competence and skill in the method used. I have read other IPA studies and previously carried out a smaller-scale analysis of a therapy session. I believe I developed some confidence in the method and began to hone my skills through this preliminary foray into IPA. In addition, I read online accounts from other students of IPA and consulted peers and supervisors to ensure the analysis was coherent.
3. **Transparency and coherence:** In some IPA studies, validity is enhanced by different researchers attending to different parts of the process. I conducted this study without co-researchers, but I believe both transparency and coherence were achieved through consultation with peers and supervisors.
4. **Impact and importance:** These factors refer to how well and/or sensitively a piece of research is conducted. This was considered during all stages of study. Perhaps the best way it can be evaluated is to consider whether or not the research tells the reader something interesting and/or useful. To this end, I have included clinical recommendations in the final chapter.

3.10 Limitations

This study is a small qualitative exploratory study. It was in one clinic only, so it is not representative of siblings who attend and/or wait for CAMHS, nationally. However, some of the themes arising from the study may be relevant to sibling dynamics overall.

Another limitation is my pre-existing relationship with and role within the clinic and some therapists who made introductions to the participants. I had to be mindful of this during the writing stage of the study and particularly in the discussion and recommendations.

In IPA studies, a sample size of 6 or under is considered small, so the 4 interviews comprise a more limited overview and no statistical generalisations can be made. However, aspects discussed in the findings might be present in the experience of other siblings in both the waiting experience and therapeutic work.

3.11 Situation of the Self in Research

This thesis is a requirement of the Child & Adolescent Psychoanalytic Psychotherapy professional doctorate at the Tavistock & Portman NHS Trust and the University of Essex. I trained within the generic team of a CAMHS clinic during the required 4 years of study and worked in a voluntary role at a primary school counselling service for 3 years prior to entering the doctoral programme.

Prior to commencing both the pre-clinical and clinical phases of the doctorate, I pursued a career as a national newspaper journalist which spanned more than 20 years. I was experienced and well-respected. This proved helpful in some ways and frustrating in others. I was often involved in nuanced investigative projects and – over time - had developed both interviewing and research techniques built on formal journalism training and instinctual experiences. Adopting the IPA approach initially felt like re-inventing the wheel and I tried to continually reflect on my reactions to this.

There were times when I felt challenged and frustrated by needing to adopt a more academic approach. I resisted, particularly struggling with the new, more complicated terminology for processes which I felt I had been adopting in a more instinctual way for years. For example, I learned that a researcher trying to make sense of a participant trying to make sense of what is happening to them is known as a ‘double hermeneutic’. In my previous career, it was more colloquially and crudely known as ‘journalistic nous’.

Learning the disciplines of academic research felt – at times – like ripping up a manual I had adhered to for decades and starting all over again. There could be a tendency for me to denigrate the process, and I needed to continually reflect on when and why this happened – usually during times when I felt most challenged and out of my depth.

I had previously undertaken some basic academic research, both at undergraduate and master’s level, but the intellectual rigour and attention to detail which this way of working required felt new and demanding. Finally, I was conducting the research through a psychoanalytic lens, which was different to my previous journalism work and its location in the more conscious realms of the here and now.

I was also mindful of my relationship and transference to the clinic (my workplace) while carrying out interviews with parents. I knew some of the clinicians who were involved with the families, but I did not know the families themselves. I think this neutral stance allowed me to approach the interviews with more confidence and curiosity, not knowing what was going to emerge.

This research is my first foray into the topic of sibling dynamics. I feel passionate about my work in CAMHS in general and this aspect of it, which I have experienced as a live issue in the consulting room. As explained in the introduction, the younger brother of a child already in treatment with me would actively try to force entry into the therapy room by barging through the door. Meanwhile, my patient would voice anxieties in relation to the unwelcome fantasy that his brother would take his place with me when he had completed treatment.

Meanwhile, my own lived experience as a sibling was a powerful driver for research on this topic. Initially, the dynamics around this were perhaps largely unconscious and more located in my patients. But as time went on, I began to see how my own complex family constellation – referred to in the introduction - might have played a part in my chosen topic.

So, in terms of theoretical orientation, I am informed by psychoanalytic thinking but – as a sibling myself – I have firsthand experience of the intense feelings of love, hate, envy, rivalry, guilt (to name but a few) which can be associated with the genre. I am also an adoptive parent and interested and well-versed in thinking about issues of difference and diversity. This mindset proved helpful in almost all the interview processes.

Finally, as an IPA researcher, I was mindful of my dual roles as therapist and researcher in the CAMHS clinic. I reviewed the transcripts several times against the findings to ensure I was reflecting on and representing the participants' lived experience of their children accurately. I kept a diary and discussed my initial findings with my supervisor to ensure that an unbiased and more detached lens was trained on the data.

I was satisfied that the sample of 4 participants – although small – provided rich and significant data. The most difficult stage was perhaps the data analysis. I therefore read other, published IPA research studies and bought Smith's revised IPA edition (2022). This provided a trusted companion alongside my research supervisor. It gave me both guidance and confidence to know that I was following the correct analysis procedure within the method at any given time.

Chapter 4: Findings

This chapter presents the findings of the study, which explored parents' lived experiences of the impact of CAMHS-based psychoanalytic psychotherapy on biological sibling relationships when one is in treatment and others are on the waiting list.

Following the methodological principles of Interpretative Phenomenological Analysis (IPA), the analysis attempts to prioritise participants' own meaning-making and attends to both convergence and divergence across cases. The chapter is therefore not intended to provide an exhaustive account of every participant's story but rather to illuminate the key patterns of experience that emerged, while honouring the idiographic detail of individual voices.

4. 1. Introduction

As fully explained in the previous chapter, the analysis of the data began with a close engagement with each transcript, following the stages suggested by Smith, Flowers and Larkin (2009). Each case was therefore examined closely using detailed line-by-line coding methods and exploratory notes were made, eventually allowing for the emergence of experiential statements. These aimed to reflect the participant's meaning-making in context. These statements were then clustered into categories, resulting in Personal Experiential Themes (PETs) for each of the four cases. Only after this detailed analysis was complete, could the process of working with the PETs to develop Group Experiential Themes (GETs) across cases begin.

The IPA cross-case analysis involved searching for points of convergence and divergence across participants, trying to identify shared experiences as well as unique or contradictory ones. The aim was not to achieve consensus, but rather to capture the richness and complexity of the phenomenon by identifying sameness alongside difference. The process was iterative and interpretative. In other words, emerging patterns were revisited in relation to the transcripts to ensure they were grounded in the data, and interpretative commentary was continually refined through reflexive engagement with the researcher's own assumptions and positioning.

The analysis retrieved four GETs:

1. Sibling Inequality and the Struggle to Be Seen
2. The Burden of Care and Blurred Identity
3. Navigating Systems of Support and Disappointment
4. Making Sense of Past Trauma in Present Relationships

A visual illustration of the process of deriving the GETs from PETs is shown in the table below:

Table 1: Group Experiential Themes Derived from the Personal Experiential Themes

GROUP EXPERIENTIAL THEMES (GETs)	PERSONAL EXPERIENTIAL THEMES (PETs)
SIBLING INEQUALITY AND THE STRUGGLE TO BE SEEN	<ul style="list-style-type: none"> - The emotional cost of sibling separation in therapy - Sibling inequality alleviated by shared treatment - Feeling pushed aside while trying to be heard - Invisible and ignored in the waiting - Sibling as parent
THE BURDEN OF CARE AND BLURRED IDENTITY	<ul style="list-style-type: none"> - Parent pulled between siblings - Carer stretched by multiple roles

<p>NAVIGATING SYSTEMS OF SUPPORT AND DISAPPOINTMENT</p>	<ul style="list-style-type: none"> - Living in emotional limbo - Taking a chance on scant support - Feelings of exclusion and mistrust in the therapy space - Fighting for sibling care in complex systems uncovers inequality and confusion
<p>MAKING SENSE OF PAST TRAUMA IN PRESENT RELATIONSHIPS</p>	<ul style="list-style-type: none"> - Parent carries children's past into future - Family fractures and emotional fallout - Trying to make sense of the wait for meaning and understanding

4.2. Use of Quotations

Throughout this chapter, verbatim extracts from four different participants are used to illustrate and support the analytic claims being made. Quotations are included not to “speak for themselves” (p112, Smith et al 2009) but to provide a foundation for interpretative commentary, consistent with IPA’s dual commitment to phenomenology and interpretation. I have endeavoured to select extracts which are particularly rich with emotion, thereby eliciting empathy and/or capturing the imagination of both reader and analyst. My intention has been

to use quotations to help vividly capture the essence of a theme or offer a particularly clear articulation of a shared (or divergent) experience. Where deemed relevant, shorter excerpts are used to highlight nuance or clarity. All participants are represented at least once within the analysis, and pseudonyms are used throughout to ensure confidentiality.

4.3. Balance Between Narrative and Evidence

The analysis attempts to present a dialogue between participants' accounts and the researcher's interpretation. In line with IPA conventions, it aims to allow the analytic narrative to take precedence, with the participants' quotations serving as illustrative evidence rather than stand-alone findings. The emphasis is therefore on understanding *how* participants made sense of their experiences, rather than on solely providing a descriptive catalogue of *what* they said. Each theme is discussed through a combination of analytic commentary and illustrative extracts. This balance hopefully ensures that the analysis remains interpretative while retaining transparency and grounding in the data.

4.4. Reflexive Note

Finally, it is acknowledged that the analysis presented here is one possible interpretation, co-constructed between participants' accounts and the researcher's engagement with them. My own background, assumptions and emotional responses inevitably shaped the analytic process. Reflexive journaling and supervision were used throughout the project to help me to endeavour to remain critically aware of these influences and to ensure that the findings remained grounded in the participants' lived experiences.

4.5. GETs and Sub-Themes

The cross-case analysis resulted in the identification of four GETs (specified above) each comprising several interrelated sub themes as outlined in Table 2 below.

Table 2: Group Experiential Themes and Relevant Sub-Themes

<u>GROUP EXPERIENTIAL THEMES</u> <u>(GETs)</u>	<u>SUB-THEMES</u>
SIBLING INEQUALITY AND THE STRUGGLE TO BE SEEN	<ul style="list-style-type: none"> • Feeling emotionally and unfairly excluded in waiting • Therapy provides attention • Comparison and rivalry • Desire for individual recognition
THE BURDEN OF CARE AND BLURRED IDENTITY	<ul style="list-style-type: none"> • Parents/ carers feel strained in their roles and guilty feelings become prevalent • Carers' own needs are suppressed • Role confusion
NAVIGATING SYSTEMS OF SUPPORT AND DISAPPOINTMENT	<ul style="list-style-type: none"> • Access inequality and referral thresholds • Ambivalence about CAMHS
MAKING SENSE OF PAST TRAUMA IN PRESENT RELATIONSHIPS	<ul style="list-style-type: none"> • Past Trauma and Fear of Family Repetition • Inherited Sibling Struggles

	<ul style="list-style-type: none"> • Search For Meaning and Connection Amidst Emotional Chaos
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Giving a brief overview, the 4 themes are:

1. **Sibling Inequality and the Struggle to Be Seen** – parents appear to notice and capture the painful position of a sibling who sits outside the therapeutic process, often feeling invisible, envious and unworthy.
2. **The Burden of Care and Blurred Identity** – explores the ways participants felt strained and stretched in their caregiving roles, trying to offer reassurance to siblings inside and outside of CAMHS.
3. **Navigating Systems of Support and Disappointment** – examining participants’ ambivalent experiences of both fighting for and reaching the threshold for therapeutic intervention.
4. **Making Sense of Past Trauma in Present Relationships** – highlighting how families appear to live in the shadow of both past and present trauma, all the while struggling to make meaning from this in the present.

This sequence was chosen because it appears to mirror the journey articulated by many participants, beginning with a recognition of the sibling relationship when strained by inequality, through the real struggle of trying to manage this as a parent/caregiver – both emotionally and through navigating systems such as CAMHS. Finally, there is a sense of

reflection on trauma and family dynamics – and what it all means. However, this order is not intended to suggest a rigidly linear or universal process; rather, it provides a conceptual framework for presenting the themes in a coherent narrative form.

4.6. Group Experiential Theme 1: Sibling Inequality and the Struggle to Be Seen

An important theme of the participants' experience of being alongside one sibling undergoing CAMHS psychoanalytic child psychotherapy while another waited for treatment was their bearing witness to a strong sense of inequality in the sibling relationship.

Parents observed how siblings left out of the therapy room appeared to feel emotionally and unfairly excluded in the waiting process. Brothers and sisters were able to experience the dynamics of undivided attention inherent in the process of psychoanalytic psychotherapy – but only as waiting room or peripheral observers. This status quo could leave the waiting sibling feeling invisible, envious, or even unworthy and fuel feelings of comparison and rivalry. Some parents noticed a desire for recognition in the waiting sibling; a yearning to be noticed as more than just 'the other child.'

4.6.1. Sub-theme: Feeling emotionally and unfairly excluded in waiting

All participants with lived experience of supporting a child in treatment and a child waiting for treatment had a strong sense of exclusion felt by the waiting child and feelings of injustice an inequality inherent in the process. Feelings of incomprehension at being within the same sibling dynamic and yet treated differently in the CAMHS system appear to have been powerfully projected into the parents and carers:

For example, Sarah, the White British biological mother of a son (trans male), 16, and daughter, 12, said:

“It happened to them too, so why wouldn't they get the same attention?” (Sarah, I:1/ P:24)

Sarah revealed how her husband – the siblings’ father – had committed suicide, an impactful trauma that both her children had endured equally. So, the family were finding it difficult to comprehend a system whereby one child – in this case the brother – was being prioritised for treatment while his sister was left to wait. She added:

“They have the same background, they have the same history and they're not being treated in the same way and that's pretty frustrating.” (Sarah, I:1/ P:52)

Other carers were directly challenged by the waiting siblings and found themselves attempting to rationalise the process. Belinda, who is White British, was left to care for her three nieces aged 13, 8 and 7, while her own sister struggled with drug addiction. Like Sarah, Belinda conveys the sense that siblings share the same trauma but do not get treated equally in the aftermath - perhaps because they do not always display simultaneous signs of distress:

“The youngest wants to know why she's not in CAMHS. Her argument is: ‘Well, I saw everything Sarah saw.’ So: ‘Good point, but you're not presenting like Sarah is so at the moment you don't need it’.” (Belinda, I:4/ P:11)

However, when a need for treatment has been recognised in both siblings but one is forced to wait or change provision, it appears to create an anxiety-provoking vacuum which the parent/carer and child have to navigate alone. Belinda explains:

“If there is a sibling already getting support and another one is waiting – already having left a provision - that's when it's most detrimental. And that's when it affects the kids and the parents the most.” (Belinda, I:4/ P:20-21)

She describes the waiting space as a void where “there’s nothing” for the waiting sibling. This place of not knowing seems particularly anxiety-provoking, as evidenced by Belinda’s repetition of the word “hardest.” In addition, Belinda appears to convey a painful emotional dimension to the sense of inequality when the waiting child is fully aware that help is available to one sibling but not the other:

“They’re just in limbo, and I think that's the hardest for the kids. I think it's difficult when they know that one's getting help and one's not. I think actually, it’s that period where there's nothing - that's the hardest.” (Belinda, I:4/ P:21)

Veronica, the White British biological mother of an autistic 18-year-old boy (trans male) in CAMHS psychotherapy treatment and a 16-year-old girl who had to wait, echoed this sense of the waiting sibling being fully aware of what they perceived to be an inequitable process:

“It was very frustrating for Laura because she could obviously see that that Jools was very comfortable and happy going into CAMHS and had made good relationships and made

good progress. She couldn't really understand why she had to wait for so long.” (Veronica, I:3/ P:5)

Meanwhile, Melissa is a Black British kinship carer who has been raising her maternal nephew, aged 13, and niece, aged 11, for several years. She also attempts to rationalise the sense of inequality by telling the waiting sibling that she is “alright” – but is met with opposition:

“I was like: ‘At the minute he needs someone to talk to. You’re alright,’ but she was like: ‘No, I’m not.’” (Melissa, I:2/ P:6)

While some of the waiting siblings protested their struggle to be seen and heard verbally, others demonstrated their anxieties somatically. When siblings were forced to enter CAMHS and experience the waiting room, they appeared to have a more concrete sense of being excluded. Sarah’s daughter Michelle had a visceral sense of being on the outside of her brother’s therapy room which sometimes culminated in breathing difficulties:

“Michelle’s going to be having a panic attack outside, but obviously not be able to bring Michelle in.” (Sarah, I:1/ P:18)

And Melissa’s noticed how her niece was more alive to a sense of injustice when inside the CAMHS building helping to facilitate her brother’s journeys to and from the service:

“‘Why am I not here?’ She did ask questions like that when we were dropping him off or picking him up. I’d just say: ‘Oh, he’s... you know, he needs a bit of support, someone to

talk to.’ Then she would say: ‘I need someone to talk to. That's not fair. I want someone to talk to.’” (Melissa, I:2/ P:6)

All the participants gave a clear sense of the challenges faced by siblings who feel sidelined in the waiting process. Meanwhile, they appeared to have a unanimous wish for CAMHS to get alongside them and the waiting sibling. Melissa seems acutely aware of CAMHS’s limited resources but her plea for “*any bit of resource*” reflects the urgent need for support. She suggests that a CAMHS clinician could reach out and say:

“Just: ‘Hi, I’m from CAMHS. Your sibling’s with CAMHS at the minute and just to let you know, you’ll be joining; you’ll be coming along soon.’ I mean, I know resources are thin but if ever there was any bit of resource, maybe even like 10 minutes once a month. Just someone introduce themselves. It doesn’t have to be the person that she’s going to be seeing.” (Melissa, I:2/ P:19)

Melissa also articulates the pressure put on carers by siblings who feel anxious and confused in the wait. She advocates for the need for a holding connection with the designated clinic – however “*simple.*” She said:

“Just simple. Just a ‘Hello’. While Sarina was waiting, she was asking: ‘When am I going to start? When am I going to start?’ Maybe a 5-minute call once a month or so.” (Melissa, I:2/ P:20)

Or:

“I think sending an occasional letter saying: ‘We know you're waiting but we've got you in mind,’ could be helpful. Or maybe something like a check in.” (Melissa, I:2/ P:19)

Meanwhile, Veronica emphasises the need for the waiting sibling to be validated both as an “individual” *and* a sibling. She also appears to elevate the seriousness of the waiting sibling’s position by introducing the concept of trauma. She suggested:

“Maybe in initial consultations there could be an acknowledgement of: ‘How have you felt with your sibling being in the service for so long? How has that affected you?’ Someone could acknowledge: ‘We know you’re an individual. We know you're not here because of your sibling.’ Acknowledge what has been happening to them – coping with a sibling’s distress - as potentially being traumatic.” (Veronica, I:3/ P:26)

Finally, Belinda empathises strongly with the position of the emotionally and unfairly excluded child. Like all the participants, she stresses the need for the waiting sibling to be recognised in some way by CAMHS. She contrasts the concept of a “number” with a “person” to emphasise how important it is for a sibling in the shadows to be fully recognised in their wait for treatment. She said:

“Making them feel that they're not just a number. They are a person by actually having their name on the text message or the email. The correspondence could be directed at the child: ‘We haven’t forgotten you. You are on the list. We are trying to get to you.’ If there is a sibling already getting support and another one is waiting – already having left a provision - that's when it's most detrimental. And that's when it affects the kids and the parents the most.” (Belinda, I:4/ P:20-21)

She conveys how important it is for siblings to be remembered:

“‘You are still on the waiting list. You haven't been forgotten.’ Something like that, I think would help.” (Belinda, I:4/ P:19)

4.6.2. Sub-theme: Therapy provides attention

The closer the waiting siblings came to the psychoanalytic psychotherapy treatment offered to their brother or sister, the more they seemed to yearn for the same undivided attention inherent in the process. Sarah noticed that:

“She (Michelle) felt like Adrian was getting all the attention.” (Sarah, I:1/ P:24)

And Melissa observed how one of her nieces who was not in treatment began to like the “idea” of having a devoted listener. There is a growing sense that it is not just the process of being helped which is yearned for but the idea of being fully seen and heard which is important.

“Then she would say: ‘I need someone to talk to. That's not fair. I want someone to talk to.’ It was the idea of having someone to talk to.” (Melissa, I:2/ P:6)

4.6.3. Sub-theme: Comparison and rivalry

All the parents and carers noticed a prevalence of feelings of comparison and rivalry between siblings when one was in treatment, and one was waiting. The waiting siblings' sense of invisibility and injustice could provoke envy.

Melissa noticed how her niece appeared to want a therapist just because her brother (Melissa's nephew) had one:

“She wanted someone to talk to because he had someone to talk to. That was the only reason at the time.” (Melissa, I:2/ P:7)

And Belinda became aware that:

“Rebecca's kind of jealous that she hasn't got a person, but she doesn't really understand what it's for.” (Belinda, I:4/ P:11)

The therapist and the therapeutic process appear to become a source of splitting among siblings – a territory to be protected and defended individually.

Melissa notices how the therapist is weaponised by the brother and sister in her care and used as a source of splitting and provocation:

“She would say: ‘I'm going to see your therapist,’ and he would get quite defensive: ‘No, you can't have my therapist.’” (Melissa, I:2/ P:8)

There is also a sense of anxiety in relation to the confidentiality inherent in the therapeutic alliance and a sense that it could be compromised by the waiting sibling. The carer Melissa appears to convey a sense of being in the middle of the two siblings, along with the therapy which also divides them:

“He would tell me privately a little bit about what he had done in therapy – like a bit of painting - and he wouldn't want her to hear that. He would say: ‘You can't tell her. Don't tell her what we're doing. I don't want her to hear what me and my therapist are doing. He didn't want her to know anything at all. That's his, that's his thing.’” (Melissa, I:2/ P:8)

The siblings are not just vying for the attention of a therapist but the carer too. The dynamic of siblings in and out of treatment creates a triad in which someone is continually left on the outside. Melissa explains:

“He didn't want her to go at the same time and didn't like the fact she was with me when we had to collect him from school. She didn't care but he wasn't happy at all. He was just in a sulk and a mood, just wasn't happy – moody: ‘Why has she got to come with me?’” (Melissa, I:2/ P:12)

Feelings of comparison are also triggered among siblings in the dynamic of existing inside and outside of CAMHS psychotherapy. When Veronica's daughter finally followed her brother into CAMHS and reached the point of assessment, she was surprised to feel that it did not appear to be replicating her brother's smooth experience. Veronica recalls:

“So, it's very much about comparison between her and him and I think she was expecting something different.” (Veronica, I:3/ P:15)

She seems to reflect that her children want equality within the system but also to be seen as individuals with different needs:

“Kids will automatically compare with what one's getting and what the other person is getting, but they also want to be individuals at the same time.” (Veronica, I:3/ P:25)

4.6.4. Sub-theme: Desire for individual recognition

Most of the participants detected a strong yearning for individual recognition in the waiting sibling; a need to feel more than just ‘the other child’ or ‘the child on the waiting list.’

Sarah’s daughter has seemingly projected this feeling into her mother quite strongly, allowing it to be expressed poignantly and empathically. Sarah reflected on her waiting daughter’s plight:

“She just needed to be held and heard.” (Sarah, I:1/ P:24)

Meanwhile, Melissa noticed that it was important for her niece to be recognised by CAMHS in an individual way which was different to her brother. She is aware that the knowledge that Sarina will have a different therapist makes her “really happy”:

“I told Sarina: ‘You’re going to be going to the same place as Kevin but you're going to see somebody else. She was really happy about that: ‘I get someone to talk to now’.”

(Melissa, I:2/ P:11)

Veronica appeared to have the most visceral experience of a child who needed to be seen as a person in her own right, separate to her sibling identity. Veronica doubly emphasises how the prospect of being seen as part of a family as opposed to an individual was “very, very difficult.” She said:

“They (CAMHS) wanted us to do family therapy and she (Laura) found that very, very difficult. So that was not the best experience for her. She was like: ‘I don't want to talk about him [Jools]. You know, we are always talking about him: ‘What about me?’” (Veronica, I:3/ P:10)

And when Laura was finally seen in CAMHS, there was still a sense that she was not being fully *seen* by professionals. Veronica adds: “

“They kept on saying she had low mood, so she didn't feel validated at all. She was coming out in tears saying: ‘They're just not listening to me. I don't want to go.’” (Veronica, I:3/ P:13)

Laura’s experience of not feeling individually recognised in CAMHS and as a sibling appears to provoke her mother to reflect further on these feelings in relation to family dynamics:

“I don’t think she always felt there was enough time for her even though we'd constantly say: ‘You know, if you want to talk, we’re here, but she’d say: ‘No, Jools has been talking’ or ‘You're probably tired.’” (Veronica, I:3/ P:22)

4.7. Group Experiential Theme 2: The Burden of Care and Blurred Identity

All the caregivers shared a feeling of overwhelming emotional strain in their task of attending to the needs of siblings who were simultaneously in therapy and waiting for treatment. They appeared to be constantly switching between roles (parent, advocate, sibling adjudicator), trying to be ‘all things to all people’ in this burden of care. As a result, guilt emerges as a prevalent feeling when they inevitably cannot meet every need of every sibling. They convey how their identities and roles have a tendency to become blurred, leaving little space for personal need or emotional recovery.

4.7.1. Sub-theme: Parents/ caregivers feel strained in their roles and guilty feelings become prevalent

Sarah uses the verb ‘pulled’ to convey the sense of strain put on her while trying to attend to the needs of her son inside the therapy room and her daughter, who is kept waiting outside - both in the reception area and on the CAMHS list. The physical aspect of the tension is palpable for both mother and daughter, who struggles to breathe in the moment. Sarah recalls:

“I’m pulled in to talk to [CAMHS care coordinator] and Michelle is left sat outside on her own and will literally have a panic attack.” (Sarah, I:1/ P:18)

Sarah appears to be acutely aware of the waiting sibling's anguish, especially when she was forced to leave her alone to attend to her son's needs inside the therapy room. The impact is deemed to be "massive":

"Leaving her (Michelle) on her own in that environment (CAMHS waiting room) was a massive trigger." (Sarah, I:1/ P:49)

There is a sense of betrayal on the part of this parent who is unconsciously and unavoidably replicating the clinic dynamic by paying one child more attention than the other. Sarah feels a need to apologise to her daughter, the waiting sibling, and conveys a feeling of guilt in the idea of breaking a promise:

"So, I would have to literally say: 'I'm really sorry Michelle, but I need to go in there (therapy room). I know I said before we came in that I wouldn't go in but [care co-ordinator] needs to talk to me. I can't ignore that. And it was like I was breaking a promise or something so Michelle would get very angry with me about it.'" (Sarah, I:1/ P:22-23)

This parent shares how she has to bear enormous distress in her daughter who is left to wait. Sarah is keen to share the length of time such a meltdown might last and to give the interviewer a visceral sense of the form it takes:

"Anger, crying, shouting at me telling me just venting to me that I promised and I broke a promise. Yeah, just lots and lots and lots of shouting and screaming basically. That can last up to half an hour. 40 minutes." (Sarah, I:1/ P:50-51)

For Sarah, the interview process appears to illicit a state of self-reflection in relation to her daughter, the waiting sibling. She empathises with Michelle's position and is keen to share that she has attempted to make other arrangements for her. The idea of having "fun" is clearly distinct from the experience of waiting and feelings of guilt remain prevalent:

"I did try to organise it so that Michelle could be at home with my mum having fun instead of sitting in that chair in the waiting room. I tried to arrange it as much as I could do over the last few years because I know Michelle doesn't like it there. I'm very conscious of that." (Sarah, I:1/ P:34)

Veronica also demonstrates a process of trying to empathise with her daughter's experience of being kept on the outside:

"So, putting myself in Laura's place I would feel a little bit lost, and a little bit left behind." (Veronica, I:3/ P:21)

And there appear to be feelings of guilt and self-blame inherent in the strain of trying to give equal attention to their children. In fact:

"It sounds really stupid, but we had no idea that she was feeling that bad." (Veronica, I:3/ P:8)

Veronica attempts to explore the "balancing act" further, citing reasons for and examples of inequality between the siblings. The language of war ("fighting", "battle") is used to convey the extent to which these parents feel strained in their roles:

“Jools might possibly have some resentments because Laura was taken out of school and privately schooled, which we couldn’t do for Jools at the time. So, it becomes a balancing act, at times, trying to meet both of their needs, because Jools’ is also transgender, so we’ve been fighting that battle for him to get treatment and things.” (Veronica, I:3/ P:21)

Meanwhile, Sarah is honest about the reality of Michelle’s physical experience of waiting for her brother in the clinic. She uses the term “fudged off” to express the idea of a process which is vague and inadequate, perhaps replicating how her daughter is being dealt with in bigger systems such as CAMHS. She confesses:

“Michelle is normally fudged off to a friend.” (Sarah, I:1/ P:8)

The sense of strain on this carer is already palpable but further evidence is provided with an insight into the state of Sarah’s health. She uses sarcasm and humour to introduce serious information about her own “needs”:

“I have blood pressure tablets because my body needs that to help my blood flow properly. Then.... I say I need therapy to make sure that I'm not going to kill both of you (son and daughter) basically.” (Sarah, I:1/ P:32)

4.7.2. Sub-theme: Carers’ own needs are suppressed

Half of the participants interviewed shared a sense of their own needs being suppressed in the burden of care. Melissa was relieved of supporting her niece with the emotional difficulties of waiting to join her brother in CAMHS when she finally joined him in the clinic. However,

she was faced with a new physical “tough” challenge of juggling their treatment on different days. Alongside sharing this, Melissa was also keen to highlight how: “I also work” – thereby giving a real sense of the small margins left for her own needs. Melissa shared the siblings’ CAMHS routine once they were both in treatment:

“She was going on a Monday and he was going in on a Thursday during the school day and that was quite tough for me. I also work.” (Melissa, I:2/ P:10-11)

This appears to trigger some frustration in her and wish for her own “schedule” or need to be considered:

“I’d say: ‘Well, it just can't work by your schedule all the time. You’ve got to think about my schedule as well.’” (Melissa, I:2/ P:14)

Melissa also introduces the idea of another set of needs which are suppressed and conflicted as a result of the process of prioritising the siblings needs. She reveals an identity as a mother to biological children as well as kinship carer for her niece and nephew:

“My daughter as well comes into it because I also have children.” (Melissa, I:2/ P:16)

And she goes on to explain the “conflicting” aspect of this dynamic and uses language like “difficult”, “stressful” and “hard” to describe a dynamic in which both emotional and physical space needs to be shared. Ultimately, the needs of the siblings take precedence “all of a sudden” and both Melissa and her biological children need to adapt:

“My daughter is 13 as well so it can be a bit conflicting and she can be a bit, you know, she had to have a bit of therapy when they first came because she was struggling with them being with us. It used to just be myself, my son and her and then all of a sudden, you know, they (niece and nephew) came, and they were quite....it was quite difficult in the very beginning. It was stressful. We were living in a two-bed flat all of us - it was hard.” (Melissa, I:2/ P:17)

Belinda also portrays herself as a carer who has sacrificed her own needs for those of both her own sibling Carol and her sibling’s children. Unlike Melissa, who describes being presented with a “sudden” change to the status quo, Belinda traces her own “caregiver” trajectory back to a young age. She conveys a sense of having had to suppress her own need for a childhood in order to take care of her sister and allow her to be “the fun one”. She recalls:

“I was the sensible, I was the level-headed. I was the mum. I was the caregiver. My sister was the crazy dad that went: ‘Let’s go climb a tree and not even think of the consequences. Let’s go jump off this bridge straight into water and not think.’ So, she was the fun one that didn’t think of the consequences. I was the one that was behind going: ‘You can do that. I’ve got the first aid kit. It’s ok.’” (Belinda, I:4/ P:29)

There is little sense of what Belinda’s own needs are now or in the past. They appear to be solely located in her need to care for her sister and nieces. She describes how she would reassure her sister:

“I've got the first aid kit. It's ok. So, I've always had to be the one that kind of took the pieces and fixed it all.” (Belinda, I:4/ P:30)

This dynamic of suppressing her own needs to care for her sister continued and repeated over time. Belinda extended her role to caring for her nieces when their mother became drug dependent. Belinda appears to view this as an ordinary extension of her role, using the term “obviously” to begin her sentence. Meanwhile, her choice of the word “intervention” is more closely aligned with the formal language of care systems than ordinary family dynamics. Belinda recalls how her caring role expanded when she became an aunt:

“Obviously, I supported - all the way through - my younger sister having children. I've moved the kids in with me for years at a time - with mum. Unfortunately, mum's drug and alcohol addiction just kept getting worse. They were back living with me on a permanent basis. That was my intervention.” (Belinda, I:4/ P:2)

The extent to which her sister and nieces' needs needed to be prioritised over her own is highlighted through Belinda's recollections:

“Mum (Belinda's sister) wasn't waking up. I was making 36 phone calls every morning to make sure she woke up to get the kids to school.” (Belinda, I:4/ P:3)

And:

“I only missed 7 night feeds for Sarah through the first year of her life. I did everything but 7.” (Belinda, I:4/ P:23)

There is only a mild sense of Belinda trying to prioritise her own needs by the time her sister gives birth to another child by adjusting the care routine:

“And by the time Rebecca was born, I was a bit like: ‘I can't Carol, I can't do it.’ So, I ended up spending most days travelling back and forth to support her that way.” (Belinda, I:4/P:28)

There is a sense of enormous struggle for Belinda to both identify and/or prioritise needs of her own alongside those of her sister and nieces. The only way to make things “simpler” is to limit contact with her sibling:

“I'm trying to get that healthy balance so unless it's contact, I just don't talk to her. It's like it's a simpler thing for now.” (Belinda, I:4/ P:31)

4.7.3. Sub-theme: Role confusion

Role confusion or blurred identity appears to be a prevalent feature of life as a carer of siblings who need considerable care themselves. Linked to the themes of feeling strained and needing to put the needs of other's first, is a sense of loss in relation to the carer's own identity and sense of self.

Both Melissa and Belinda – who are both kinship carers to their sisters' children – describe the idea of role confusion: Melissa reflected:

“Yeah, sometimes I’m mum, sometimes I’m auntie. I’m both.” (Melissa, I:2/ P:2)

Belinda added:

“I’m always Belinda or Bel Bel or Auntie. Rebecca will throw a ‘mum’ in when she really needs me. Sarah's first word was: ‘mum’, and that was actually directed at me, not my sister.” (Belinda, I:4/ P:31)

For Belinda, there is a sense of weary resignation in the way she conveys her loss of identity – perhaps also linked to the suppression of her own needs:

“So, whatever they call me – as long as I’m not been sworn at – I’m like: ‘Yeah, hi, I’m here. What do you want?’” (Belinda, I:4/ P:32)

While assuming multiple roles may trigger both mental and physical exhaustion, there is also a sense of confusion inherent in the dynamic. Belinda and Melissa are not just straddling multiple roles as carers but as siblings themselves. Belinda wonders about the boundaries of her role as kinship carer in relation to her sister:

“I want to call her up. I want to go up to her and be like: ‘Sort yourself out. Do this; do this; do this; so that you don't lose your child.’ But I'm like, am I even allowed to as a kinship carer?” (Belinda, I:4/ P:31)

The dynamic triggers strong feelings for Belinda such as betrayal:

“I feel like I'm betraying her but also, I can't support her. I have 5 kids.” (Belinda, I:4/P:30)

And she reflects on the painful dilemma of trying to occupy different roles:

“So, it's really hard now because I've basically been my sister's parent. I've basically been my sister's caregiver since I was 15.” (Belinda, I:4/ P:28)

4.8. Group Experiential Theme 3: Navigating Systems of Support and Disappointment

Parents and carers shared lived experience suggesting that access to support for some siblings seems inconsistent and often feels unfair. Families are forced to tread a complex path supporting siblings in and out of care (with all the difficult dimensions that entails) while navigating challenging NHS systems steeped in inequality and bureaucracy.

In some cases, families reflect on how a waiting sibling has to justify and even escalate levels of disturbance to be seen and heard in CAMHS. This may create a certain sense of mistrust in services in general and ambivalence about psychotherapy treatment on offer.

4.8.1. Sub-theme: Access inequality and referral thresholds

Sarah expresses incredulity at the idea that her younger child had to wait for CAMHS treatment and highlights a sense of inequity in a process whereby the eldest sibling was admitted first. She stresses how the children have the “same background” and “the same issues that happened to them”. She said:

“I'm quite surprised at how unhelpful they've been with Michelle, considering she's got the same background. She has the same issues that happened to them. Because they were younger doesn't mean that they didn't understand it.” (Sarah, I:1/ P:51-2)

Sarah feels powerless in a dynamic where she is “not allowed” to give her waiting child access to a therapy room already occupied by her brother. There appears to be a great deal of empathy for Michelle and perhaps a mirroring of the CAMHS sibling dynamic whereby one child is seemingly held more in mind than the other. Sarah recalled:

“I would say: ‘I can't bring you in, Michelle. I'm not allowed to bring you in. This is a private conversation about Adrian and again you know.....it's all about Adrian.’ (Sarah, I:1/ P:49-50)

This parent has a perception that CAMHS' referrals are triaged in relation to “high risk” and perceives this as a barrier to Michelle's needs being met – despite being significant. She said:

“I'm like: ‘Well, I don't think CAMHS will take you because you're not high risk enough.’” (Sarah, I:1/ P:24)

Meanwhile, Veronica shared that her daughter's desperation to achieve equitable treatment to her brother had actually resulted in an overdose:

“She had read somewhere that you could get forwarded up the list in CAMHS if you attempt to take your own life.” (Veronica, I:3/ P:5)

Some of the participants conveyed feelings of bureaucratic frustration in relation to a CAMHS system which they appeared to view as rigid and lacking in a sense of partnership with parents or the wider family. Sarah's comment: "you get what you're given" implies a system which cannot bend to subjectivity. She said:

"So, with CAMHS, you get what you're given and that can be a little bit frustrating because if your child doesn't gel with them, you can't ask for someone else." (Sarah, I:1/ P:6)

The idea of a system lacking in the capacity for subjectivity is also borne out in Melissa's experience of a child's needs being assessed through "forms" and "a tick box":

"You have to do these forms. It's like a tick box and you basically say how the child's feeling and you give it ratings, and it came back as: 'Yeah, your child needs some support with their mental health.' You fill that in and from that they tell you whether or not your child needs some extra support." (Melissa, I:2/ P:3)

4.8.2. Sub-theme: Ambivalence about CAMHS

A lack of faith in the CAMHS system generally compounded by bureaucratic frustration seemed to contribute to an ambivalent feeling about psychotherapy among parents when the waiting siblings eventually made their way to the front of the treatment queue.

Veronica openly questioned the relationship between her daughter and the assessing clinician:

“She didn't seem to get on with the initial person who was seeing her.” (Veronica, I:3/P:13)

And Belinda reported how her niece's awareness of her sibling's therapist led to complex feelings of degradation. Did the therapist need to experience feelings of being cast-off and rubbished like the waiting sibling? Belinda explained:

“She's already signed off [Sarah's therapist]. She's like: ‘I don't like her. She's rude. I've seen the way she looks at me when she collects Sarah’ and I'm like: ‘That's a presumption’.” (Belinda, I:4/ P: 15-16)

Belinda herself expresses a feeling of being shut out and cut off from the workings of CAMHS and more specifically psychotherapy. This position of not knowing and not understanding the machinations of psychoanalytic thinking leads her to feel “worry” and question whether CAMHS has a good enough understanding of the children in her care. She said:

“All 3 of them are completely different children. And it's trying to figure out what works for which one. I wonder if psychotherapy is what she needs. I question whether she needs something a bit more direct. I understand doing it this way allows more interpretation. But I don't know. Obviously, I'm not a professional, I don't fully understand it all. From what Sarah says when she comes out: ‘I played this, I played that. It always makes me kind of worry slightly what interpretation things are being taken with, because I know the other day she was talking about how she decided to start beating up babies in the session. What are

people going to be thinking. Oh my! I asked her: ‘Why did you beat up the baby?’ She said: ‘Well, they were bad.’” (Belinda, I:4/ P:16-17)

Veronica also expressed a feeling of being in the dark and not knowing in relation to the CAMHS system and her daughter, the waiting sibling. She described a feeling of “going round in circles”:

“I don't even really know half the time what they were doing with her, going around in circles, trying to decide, you know, the future treatment. All this time she'd be going round in circles.” (Veronica, I:3/ P:13)

There is a sense that the waiting sibling has been fobbed off with something inadequate which doesn't feel “big enough” to accommodate the problem. Veronica conveys a sense of something being minimised by CAMHS:

“She said the fact that she was having hallucinations, but they just put it down to ‘strange experiences’ which she didn't feel was big enough for what she was going through.” (Veronica, I:3/ P:14)

Finally, Belinda conveys the idea of “stigma” attached to CAMHS and the idea that a service designed to help might cause more harm or “turmoil”. There appears to be little faith that parents and carers of siblings can simply sit back and relax in the knowledge that their children will be looked after without complications:

“CAMHS has that stigma of it being about mental health and things like that. So, it's causing her a lot more turmoil, the idea of coming to a facility like this.” (Belinda, I:4/ P:12)

4.9. Group Experiential Theme 4: Making Sense of Past Trauma in Present Relationships

This theme illustrates how families live in the shadow of past and present trauma. Emotional struggles pass between members, including siblings, and are sometimes unspoken. Over time, understanding and empathy may emerge, but only through a shared sense of struggle and healing.

4.9.1. Sub-theme: Past trauma and fear of family repetition

Most of the participants spoke of trauma and pathology inherited from other family members. They showed concern about this being passed on to sibling children. Sarah made links between her daughter Michelle and her late husband, who committed suicide. There is a sense that this parent is walking on eggshells waiting for something which she believes may be latent in her daughter to ignite. She said:

“Michelle has (dad's) tendencies to hide things, bottle things and then explode at something stupid, nothing.” (Sarah, I:1/ P:44)

It is clear that significant family tragedy makes its mark in many ways, including a fear of contagion and/or repetition. Sarah said:

“Adrian expressed a lot of suicidal thoughts themselves to the grief therapist.” (Sarah, I:1/ P:3)

She added:

“Adrian still hurts himself occasionally, nowhere near as much as he did, but he still does occasionally.” (Sarah, I:1/ P:47)

Meanwhile, Melissa reflected on how her niece and nephew had been impacted by witnessing trauma, including domestic violence. She said:

“They’ve been through quite a lot with their parents, biological parents, you know, that upheaval with them. Domestic abuse and things like that.” (Melissa, I:2/ P:1)

She reflected on how her niece – who initially appeared stable – eventually developed “concerns”. Like Sarah’s experience, there is a sense that trauma can lie dormant, but history will eventually repeat itself. Melissa said:

“But as time went on, she started displaying certain concerns as well.” (Melissa, I:2/ P:7)

4.9.2. Sub-theme: Inherited sibling struggles

Three of the participants reflected on how one sibling could both inherit struggles from past generations as well as from the other sibling. Veronica conveyed the idea that her children are

individuals and yet still part of the same family with problems that seem related and deeply embedded “within their heads.” She said:

“Two children within the same family are still individuals but I think a lot of it does tie in together as well. The same sort of problems within their heads in the same sort of way - like school refusal or hiding upstairs from people coming over things like that - it would manifest itself in very similar ways.” (Veronica, I:3/ P:23-24)

One sibling inevitably treads the path of another. In Veronica’s case, she tracks chronological similarities in her children’s disturbance. She describes how her daughter followed a similar mental health trajectory to her brother:

“And her problem started the same sort of age as Jool’s really. Last year of primary school, she started to become very anxious, quite depressed. She started to experience hallucinations and ‘unusual experiences,’ I think they say. She was very anxious.” (Veronica, I:3/ P:4)

She communicates a sense of inevitability in relation to mental health problems in the context of “massive” family history. It is as if her children are swimming against an inevitable tide of systemic disturbance. She said:

“And considering the massive family history we have. We have bipolar on my side of the family and [husband’s] dad had a breakdown. So, there is a strong history of anxiety and depression, things like that already within the family.” (Veronica, I:3/ P:19)

Veronica also alludes to the possibility of trauma being passed from one sibling to another after bearing witness to distressing behaviours. She said:

“Laura potentially has a lot of trauma from when Jools was going through school refusal and things like that.” (Veronica, I:3/ P:20)

And when Laura took an overdose, it was Jools who felt impacted by his sister’s despair.

Veronica said:

“When she took the overdose, it was difficult for Jools. Yeah, he was really worried. But, before, when he was feeling suicidal, Laura was always really worried about him. So, the love and care has always been there - but voicing it to each other was difficult.”
(Veronica, I:3/P:23)

Sarah appears to debate the differences between nature and nurture when it comes to her daughter’s negative pre-conceptions about therapy:

“So, I don’t know if that’s a personality thing or if it’s them watching Adrian go through it; watching me go through it and thinking: ‘Well, it hasn’t really helped them. They still lose their temper. They still cry.’” (Sarah, I:1/ P:46)

Belinda also recalls how her own behaviour was impacted by her sister’s disturbance:

“I got expelled from boarding school because I got told my sister was being put into care.” (Belinda, I:4/ P:27)

And later, while helping to parent her own sister's siblings, she was able to observe how their mother's limited resources shaped their behaviour, triggering competition. She said:

“There was constant competition between all 3 of them for mum's attention.”

(Belinda, I:4/ P:5)

The dynamic triggered splitting between the sisters, with the eldest attempting to assume a parental role:

“Davina often divided, but she also played a kind of a head game of: ‘All listen to me.

No one listen to mum’” (Belinda, I:4/ P:6)

Belinda was able to notice the way that pathological patterns of relating which had developed between the siblings went onto shape their behaviour in other relationships:

“With Davina, this continues now even through her intimate friendships, her adult or teenage friendships. She's always got to push someone away, push someone out, isolate someone.” (Belinda, I:4/ P:6)

4.9.3. Sub-theme: Search For meaning and connection amidst emotional chaos

It is evident that all the participants involved in the study have needed to attempt to navigate painful periods of emotional chaos both for themselves and the siblings in their care. The search for meaning in this process is complex and there is a sense of parents and carers

needing to meet children where they are at as opposed to imposing pre-conceived ideas.

Sarah demonstrates how her daughter is averse to dealing with emotional chaos at this moment in time, referring to it as “stuff”. By referring to her daughter as a third person pronoun ‘they’ (something she did throughout the interview), Sarah also appears to invoke a sense of separation; needing to keep others at arm’s length. She said:

“They weren't willing to talk about [dad]. They don't think it's an issue. They think school is more of an issue. Friendships are more of an issue. Day to day life is more of an issue. ‘Not that stuff, is what she says.’ (Sarah, I:1/ P:25)

Melissa describes the meaning of her niece’s distress as an entity which did not fit neatly into mental health tick boxes, and she needed to wait for meaning to emerge:

“It's only as time went on and she started showing concerns but at the very beginning when we were doing the forms, I don't recall her showing any major concerns really with mental health. It happened a bit later on. She was a lot younger. She wasn't really showing concerns. When I was doing the forms, it wasn't a situation where there was major concern for her.” (Melissa, I:2/ P:4)

Meanwhile, Sarah and Veronica are able to reflect on how their children have been able to make better connections since experiencing psychotherapy. Sarah describes how Adrian has made “real friends” and is beginning to find more meaning in his life. Sarah said:

“Adrian is in a much better place this past year, being at college making friends, real friends, friends who give a damn about him, who want to spend time with him, who actively

seek him out when he walks in. That's made a massive impact to Adrian's life." (Sarah, I:1/P:43)

Veronica seems to echo this position, speaking about her son Jools. There is a sense of people feeling more comfortable in their own skin, more at "home":

"He's come an awful long way so the service for him has been fantastic. Everyone's really lovely and accepting – they know he's autistic and everything. And you know, they're just really, really, lovely people. It's like home from home now." (Veronica, I:3/ P:2)

Notably, both these mothers who were interviewed separately, appeared to break down and cry at this point in the interview when they spoke about their children making meaningful connections with others. This is in contrast to experiences of loneliness and separation as a result of family traumas and CAMHS splitting of sibling relationships. The process of healing in one sibling appears to lead to healing in their familial bond. Veronica conveyed a sense of brother and sister growing up and reaching a position of greater, mutual understanding:

"I'm not saying things are perfect, but maturity on both of their sides has just come through." (Veronica I:3/ P:20)

Chapter 5: Discussion

This chapter discusses the findings of this study in relation to the original research question, existing literature, and the methodological framework of interpretative phenomenological analysis (IPA).

The aim of this research was to explore the impact of CAMHS-based psychoanalytic psychotherapy on biological sibling relationships when one child is in treatment and others are on the waiting list. This was achieved by a qualitative study of parent's and caregiver's perspectives.

The analysis revealed 4 Group Experiential Themes (GETs):

1. Sibling Inequality and the Struggle to be Seen
2. The Burden of Care and Blurred Identity
3. Navigating Systems of Support and Disappointment
4. Making Sense of Past Trauma in Present Relationships

5.1. Sibling Inequality and the Struggle to Be Seen

One of the most striking findings in this study was the extent to which parents and carers observed inequality between siblings when one child received CAMHS psychoanalytic

psychotherapy and another was left waiting. The emotional weight of this experience was expressed repeatedly in participants' accounts, with waiting siblings described as feeling invisible, excluded, envious, or unworthy. Parents were caught in the painful position of witnessing this inequity, sometimes attempting to rationalise it, but often recognising its lasting emotional impact.

This theme resonates strongly with the literature on sibling dynamics within psychoanalysis, particularly the writings of Juliet Mitchell (2003, 2013, 2023) and Prophecy Coles (2003). Mitchell famously described siblings as figures who evoke both love and murderous rivalry, threatening the child's sense of uniqueness while simultaneously offering the possibility of recognition and companionship.

The findings in this study bring Mitchell's theoretical insights into sharp focus with waiting siblings often conveying a desire to be seen as unique young people with their own needs and wants. However, many of them had endured the same life events as their siblings and subsequent trauma. As a result, they wanted equal rights to therapy and when denied this recognition, it appeared to confirm their fears of being unimportant and relegated to the margins.

The sense of exclusion observed in this study also echoes Coles' (2003) lament that siblings have historically been ignored in psychoanalytic theory, almost as though they could be wished away by being overlooked. Just as Coles argued that analytic orthodoxy enacted a fantasy of the only child, the CAMHS system — by privileging one sibling's entry into psychotherapy while consigning the other to a waiting list — appeared to enact a comparable fantasy.

This created conditions in which rivalry flourished. Waiting siblings protested, became jealous, or even somatised their distress through panic attacks and suicide attempts. These findings support the idea that systems can unconsciously reproduce sibling dynamics, intensifying rather than alleviating them.

At the same time, the parents in this study showed deep empathy for their waiting children. Sarah, for instance, struggled with guilt as her daughter Michelle panicked outside the therapy room. Meanwhile, Belinda's accounts emphasised how painful it was to explain to her nieces that one was deemed "in need" while another had to wait. These parents' narratives highlight the additional burden placed on carers, who were forced to witness their children re-enacting the inequalities described in psychoanalytic theory within the clinic itself.

From the perspective of literature which focusses on the concept of waiting, these findings also fit with broader critiques of how health systems position waiting as absence. Salisbury et al. (2023) argue that waiting is intrinsic to care, but in practice, waiting can often be experienced as neglect or failure, particularly when communication is not forthcoming.

Participants in this study echoed that point, pleading for CAMHS to at least offer a letter, a check-in call, or a symbolic gesture of recognition to waiting siblings. This aligns with Woodhouse's (2006) description of waiting as a time characterised by uncertainty and anxiety, which is only tolerable when families feel "held in mind." For the waiting siblings in this study, being ignored was not a neutral pause but an emotionally charged experience of exclusion that seemed to leave psychological scars.

Comparison and rivalry emerged as a natural by-product of this inequality. Mitchell (2003) suggested that rivalry can sometimes channel envy into creative competition, but in this study, rivalry often felt pathological. Siblings weaponised the therapist as a scarce resource, turning them into a badge of superiority or exclusion. Melissa's account of her nephew defending ownership of his therapist illustrates how psychotherapy itself became a contested territory. This not only strained sibling bonds but also risked complicating the therapeutic alliance by infusing it with external rivalry.

The desire for individual recognition, another sub-theme, strongly echoes the work of Jeanine Vivona (2013), who argued that identity cannot be understood without taking both lateral (sibling) and vertical (maternal) transference into account. Participants' accounts revealed that waiting siblings longed to be recognised as distinct individuals, not merely as appendages of their brother or sister's treatment. Veronica's daughter Laura, for example, resisted being drawn into family therapy because it once again placed her in relation to her brother rather than acknowledging her as a unique individual.

This brings into view Coles' (2003) writings on sibling transference — an experience in which the therapist might be viewed as a brother or sister rather than as themselves. Conversely, a therapist's own transference and countertransference might result in a patient being seen more as a sibling and less as a person in their own right – especially when they are the second sibling to enter CAMHS.

Interestingly, some waiting siblings reacted to feelings of exclusion and associated rivalry through somatic symptoms such as panic attacks or even a suicide attempt. This echoes Klein who highlighted the painful feelings of exclusion present from the moment an existing child

is forced to contend with a sibling. Sherwin-White (2014) reminds us how: “Klein states unequivocally in a number of her cases that it was the birth of a sibling that triggered the outbreak of his or her neurosis and/or exacerbated previous difficulties.” Is a similar process re-occurring when a sibling is ‘born’ to CAMHS and the waiting child is forced to do the hard emotional labour outside the therapy room? For Sarah’s daughter, Michelle, the act of waiting outside the therapy room quite literally took her breath away. Such visceral experiences highlight how institutional practices can intensify intrapsychic conflict, with real consequences for mental and physical health.

A notable point of divergence from existing literature is that while Mitchell and Coles theorised rivalry and exclusion largely in abstract terms, this study provides vivid, contemporary evidence of how systemic waiting lists concretely reproduce these dynamics. And where psychoanalytic theory has often overlooked institutional dimensions, these findings suggest that sibling rivalry is not only an internal or familial process but one exacerbated by health-care structures. In this sense, CAMHS does not merely reflect pre-existing sibling dynamics but actively participates in their production.

Reflexively, it is important to acknowledge my own position as a clinician working within CAMHS. I am aware that my frustration with long waiting lists may have sensitised me to participants’ narratives of exclusion. At times, I found myself empathising strongly with parents’ pleas for recognition of waiting siblings, perhaps because of my own discomfort with the system’s limitations. Nevertheless, the consistency of this theme across all participants suggests that the sense of sibling inequality is not merely my projection but a lived reality for these families.

In summary, the theme of sibling inequality and the struggle to be seen provides a powerful illustration of how psychoanalytic theory and clinical practice converge. The literature on siblings helps explain why exclusion provokes such deep feelings of envy and invisibility, while the literature on waiting contextualises why these experiences are so painful within the CAMHS setting.

This theme therefore extends existing theory by showing how institutional waiting can replicate and magnify sibling dynamics, creating new layers of inequality that families are left to navigate. It highlights the urgent need for services to adopt practices that symbolically and practically acknowledge waiting siblings, even in small ways, to mitigate the potentially harmful effects of exclusion.

5.2. The Burden of Care and Blurred Identity

The second major theme to emerge from participants' accounts concerned the immense strain placed on parents and kinship carers as they navigated the complex dynamics of supporting both a child in therapy and a waiting sibling. The interviews revealed a picture of caregivers pulled in multiple directions — parent, advocate, emotional container, and sometimes sibling adjudicator — all while suppressing their own needs.

This multiplicity of roles left participants feeling guilty, exhausted, and unsure of their own identities. Meanwhile, a sense of blurred boundaries in caregiving was especially acute among kinship carers, for whom familial ties, parental responsibilities, and systemic demands became entangled.

Sarah's description of being "pulled" between her son inside the therapy room and her daughter waiting outside exemplifies the physical and emotional strain felt by caregivers. Her accounts of Michelle's panic attacks in the waiting room and her own feelings of guilt for leaving her daughter alone vividly capture the impossible balancing act.

Such accounts resonate with attachment perspectives on parenting, particularly Dunn's (2014) argument that children's sibling relationships are shaped by their sense of parental availability. Here, parents were acutely aware that the system placed them in positions where their attention was stretched and inevitably uneven, leaving them vulnerable to accusations of neglect from their waiting children.

In psychoanalytic terms, Winnicott's (1960) concept of the "good enough mother" is relevant. While Winnicott emphasised that maternal failures are necessary for healthy development, the participants' experiences suggest that systemic conditions — particularly waiting lists — transformed ordinary failures into more traumatic ruptures. Parents described these ruptures not as constructive frustrations but as unbearable betrayals, confirming the child's fear of being unimportant.

Almost every participant spoke of guilt as a dominant emotion. Sarah apologised to Michelle when forced to break promises, while Veronica described feeling shocked that her daughter's struggles had gone unnoticed. These narratives highlight the internalisation of systemic failures as parental failures. Despite recognising that waiting lists were beyond their control, carers blamed themselves for their children's distress. This appears to demonstrate how systemic inequalities can amplify guilt to intolerable levels.

Bank and Kahn (1982) argued that siblings often carry unresolved family dynamics, including guilt and rivalry, into adulthood. In this study, it was not only siblings but carers who bore the psychic weight of guilt, suggesting that institutions like CAMHS play an active role in generating such intergenerational dynamics.

Meanwhile, Melissa's account of juggling therapy appointments with her job and caring for her biological children underscores how little space was left for her own needs. And Belinda traced her caregiving role back to childhood, describing herself as the "sensible one" who had always looked after others. In both cases, self-care was sacrificed to meet the demands of children, siblings, and the system.

Meanwhile, role confusion emerged most starkly among kinship carers. Melissa acknowledged being "sometimes mum, sometimes auntie," while Belinda described how her nieces sometimes called her "mum." These blurred roles reflect what Haas-Lyon (2007) described as sibling transference, where the boundaries between sibling, parent, and child identities collapse under strain. In this study, role confusion was not confined to the therapy room but pervaded everyday family life, creating uncertainty about authority, responsibility, and identity.

Belinda's reflections on whether she was "allowed" to confront her sister about parenting highlight how kinship carers often navigate ambiguous boundaries between personal and institutional authority. This illustrates the ethical complexity of caregiving in contexts where carers must simultaneously be parents, siblings, and social workers.

While psychoanalytic literature has long acknowledged concepts such as guilt and feelings of split identity, the specific toll on sibling carers — the sheer exhaustion of trying to be all things to all people — has received less attention. Sarah's tongue-in-cheek comment about needing therapy herself is more than a humorous aside; it highlights the seemingly unsustainable demands placed on carers. These findings extend the literature by emphasising how systemic waiting structures not only affect children but also profoundly shape carers' well-being and identity.

As a researcher, clinician and mother myself, I found myself occasionally identifying with participants' accounts of being stretched beyond capacity. I too am often required to juggle multiple identities — therapist, advocate, parent, sibling, daughter, partner – all within a single day. This parallel process heightened my empathy for carers' struggles and may have led me to highlight their burden more strongly. Nevertheless, the consistency of these accounts across participants suggests that the burden of care is an authentic and central theme.

The burden of care and blurred identity theme highlights how parents and kinship carers are stretched to breaking point by the demands of supporting children both inside and outside CAMHS. Their guilt, role confusion, and suppression of individual needs show how systemic structures exacerbate and entrench these dynamics.

Services must therefore consider not only the needs of children but also the invisible weight borne by their carers, whose blurred identities and suppressed needs risk becoming an unacknowledged casualty of supporting siblings who wait.

5.3. Navigating Systems of Support and Disappointment

The third central theme concerned families' experiences of navigating CAMHS and wider systems of support. Participants consistently described their encounters with services as fraught with inconsistency, bureaucracy, and feelings of exclusion.

While families expressed gratitude for the support received by the sibling in therapy, they also spoke of frustration, mistrust, and, at times, disillusionment with CAMHS. The waiting process became a symbol of institutional failure, creating ambivalence about psychotherapy itself.

Several carers described the pain of watching one child receive help while another was left waiting. Sarah, for instance, was incredulous that her daughter, who shared the same trauma of her father's suicide, was excluded from therapy while her brother was prioritised. Such accounts highlight the arbitrariness of referral thresholds, which often left families questioning why one child was deemed "high risk" while another was not. Veronica's daughter even attempted an overdose in the belief that this would move her up the waiting list.

These narratives resonate with the literature on waiting in the NHS. Salisbury et al. (2023) note that while waiting is intrinsic to care, political and managerial changes have reframed it as service failure. For the families in this study, waiting was indeed experienced as failure — not just of time management but of recognition. The unequal distribution of access echoed

Mitchell's (2003) insights about sibling rivalry: when one child is prioritised, the other feels annihilated, unseen, or compelled to escalate distress in order to be noticed.

Meanwhile, parents often felt trapped in what they perceived as a rigid, bureaucratic processes. Sarah's comment that "you get what you're given" reflects a perception of CAMHS as inflexible and dismissive of individuality. And Melissa's account of completing tick-box forms highlights how subjective emotional realities were reduced to cold, measurable categories. These experiences highlight the dangers of over-reliance on assessment tools, which risk stripping away nuance and meaning.

Woodhouse (2006) similarly argues that waiting in healthcare contexts is only tolerable when patients feel held in mind. In this study, the absence of meaningful contact during waiting created a vacuum in which frustration and mistrust flourished. Parents' calls for even small gestures — a phone call, a letter, a name in correspondence — underline the importance of symbolic recognition.

Ambivalence emerged as a strong feeling across participants' accounts. While some valued the therapy received by one child, they also questioned whether it was the right kind of intervention for another. Belinda worried that her niece's therapist might misinterpret her play, while Veronica doubted whether her daughter's assessor understood her struggles. Such mistrust extended beyond individual clinicians to CAMHS as an institution.

This ambivalence aligns with psychoanalytic ideas about transference, where therapists may unconsciously evoke sibling dynamics of rivalry, exclusion, or dismissal (Vivona, 2013; Haas-Lyon, 2007). However, the findings here extend this concept to CAMHS itself, which

was often experienced as a sibling-like entity, favouring one child while neglecting another. In this sense, systemic ambivalence became embedded in family narratives, sometimes leading to stigma or fear that therapy might cause more harm than good.

Perhaps the most troubling finding was that some waiting siblings escalated their distress to attract attention. Veronica's daughter's overdose starkly illustrates the risk of systems that appear to reward crisis. This echoes Ansfield & Richards' (2000) concept of the "replacement child," where parental or systemic focus on one sibling leaves another desperate for attention. In CAMHS, the implicit message seemed to be that one must demonstrate sufficient risk to merit recognition.

This finding diverges from some existing literature, which conceptualises waiting as passive. Here, waiting was anything but passive: it became an active, painful process in which siblings sometimes resorted to dangerous behaviours to create noise in their perception of institutional silence.

Navigating systems of support and disappointment reveals how CAMHS can inadvertently reproduce sibling dynamics of inequality and rivalry through its structures and processes. Families experienced access thresholds, bureaucracy, and institutional silence as sources of mistrust and ambivalence, sometimes pushing children into escalating distress. This theme extends psychoanalytic insights by demonstrating that institutions, like siblings, can function as figures of exclusion and rivalry, shaping family dynamics in profound ways.

5.4. Making Sense of Past Trauma in Present Relationships

The final theme highlights how families carried past traumas into their present struggles with CAMHS. Participants' accounts showed that earlier losses, fractures, and painful experiences shaped how they interpreted current inequalities, waiting processes, and sibling relationships. The act of waiting was not experienced in isolation but as part of a longer history of trauma.

Sarah reflected on how both her children had endured the trauma of their father's suicide, making it incomprehensible that only one was prioritised for therapy. Belinda described how her nieces had lived through their mother's drug addiction, leaving her to pick up the pieces. These stories demonstrate how families experienced waiting lists not as neutral delays but as re-enactments of past neglect, abandonment, or inequality

Freud's (1920) concept of the "compulsion to repeat" demonstrates how unprocessed trauma re-emerges in new guises, demanding recognition. Similarly, the waiting sibling's exclusion echoed earlier experiences of loss, confirming fears of being forgotten or unworthy.

Meanwhile, Mitchell's (2003) insights into sibling rivalry also take on new dimensions in this context because rivalry is no longer only about envy but about survival in the shadow of trauma.

Rustin (2007) argued that siblings are always present in the psyche, whether real or imagined. Families in this study seemed haunted by absent siblings — those lost to depression, addiction, or systemic neglect — as well as those waiting outside therapy rooms. For some children, the waiting sibling was perhaps not only a rival but also a reminder of earlier losses, intensifying feelings of guilt and neglect.

Participants also sought meaning in the waiting process. Some attempted to rationalise it, telling themselves or their children that resources were limited; others described it as a “void” or “limbo” where nothing happened. Waiting became a site of both suffering and storytelling, where families struggled to gain coherence from systemic silence.

A key divergence from existing literature is the recognition of institutions as potential sources of trauma. While psychoanalytic theory often situates trauma within intrapsychic or familial contexts, these findings suggest that institutions themselves can inflict it. Being left on a waiting list, with no recognition, was experienced not just as frustrating but retraumatising — reviving earlier wounds of neglect. This expands psychoanalytic thinking by situating trauma within socio-institutional dynamics.

Listening to families’ trauma narratives often stirred strong countertransference reactions in me, including sadness, anger, and helplessness. I noticed a pull to rescue participants from their pain, which reminded me of the importance of supervision in maintaining analytic perspective. Reflexively, I acknowledge that my sensitivity to this trauma may have shaped the way I emphasised this theme.

This final theme of making sense of past trauma in present relationships reveals how waiting is never a neutral process but one layered with ghosts from the past. Families experienced CAMHS waiting lists as reminders of earlier losses, amplifying sibling rivalry and undermining trust in services. This theme highlights the need for institutions to recognise the histories that families carry with them and to avoid compounding trauma through silence or neglect.

5.5 Difference and Rivalry

A recurring thread within the findings relates to experiences of difference between siblings, often accompanied by feelings of rivalry, exclusion and injustice. While not always explicitly articulated in these terms, these dynamics appear to become particularly heightened in contexts where one child is afforded access to therapeutic attention while another remains waiting. Parents described the emotional impact of this difference, often observing feelings of envy, resentment, and a sense of being overlooked in the waiting sibling.

These reflections on difference and rivalry may also be understood in relation to the psychoanalytic literature on sibling relationships. Mitchell (2003, 2013, 2023) describes the sibling as a figure who both disrupts and defines the child's sense of self, introducing a fundamental experience of not being unique. This can give rise to powerful feelings of rivalry, as well as processes of identification. Similarly, Coles (2003) writes about the intensity of sibling relationships, in which love and hostility are often closely bound, and where feelings of envy and competition may be difficult to acknowledge directly.

What feels particularly significant in the context of this study is how these dynamics may be shaped by the structures of CAMHS, where differences in access to therapeutic support can render such experiences of difference and rivalry more acute. In this sense, the findings appear to both resonate with existing psychoanalytic understandings and extend them, by situating sibling rivalry within the lived experience of waiting and institutional difference.

5.6. Strengths and Weaknesses

A key strength of this study lies in its attention to a gap in psychoanalytic and CAMHS-related research. Although psychoanalytic theory has long recognised rivalry and exclusion within sibling relationships, very little attention has been given to the role of health-care systems in potentially replicating and intensifying these dynamics. This project makes an original contribution by showing how CAMHS waiting lists can act as a mechanism of exclusion that magnify rivalry, invisibility, and envy between siblings. It also highlights the huge strain which such dynamics can place on parents and carers who are already burdened with the task of attempting to contain mental health problems in their children.

Methodologically, the use of IPA provided a sensitive and flexible framework for analysing the carers' narratives. It enabled a close, detailed engagement with participants' lived experiences while also situating those experiences within broader psychoanalytic and systemic contexts.

The four Group Experiential Themes (GETs): Sibling Inequality and the Struggle to be Seen; The Burden of Care and Blurred Identity; Navigating Systems of Support and Disappointment and Making Sense of Past Trauma in Present Relationships captured both the depth and complexity of family life under the strain of unequal access to sibling therapy.

However, there are limitations that must be acknowledged. The small sample size, typical of IPA studies, means the findings cannot be generalised to all families within CAMHS.

Furthermore, the reliance on parents' and carers' accounts means that the voices of siblings themselves are heard through third parties, raising the possibility that some nuances of their experience remain hidden. My own position as a CAMHS clinician also shaped the lens

through which I heard and analysed the participants' narratives. While reflexivity was used to acknowledge this, it remains a potential source of bias.

Chapter 6: Conclusion

The aim of this thesis was to explore the impact of CAMHS-based psychoanalytic psychotherapy on biological sibling relationships when one child is in treatment and others are on the waiting list.

While psychoanalysis has offered some substantive theoretical thinking on sibling rivalry, loss, and identity, it has historically neglected the lived experience of siblings in clinical contexts. There is a dearth of exploration where systemic conditions such as waiting lists impact on the sibling dyad. So, by drawing on parents' and carers' perspectives and using Interpretative Phenomenological Analysis (IPA) as the method through which to explore new insights, this study sought to shed light on a neglected area of research and practice.

This chapter attempts to reflect on what has been learnt through the research process, the strengths and limitations of the work, and the ways in which the findings relate back to the research question. It also considers how the research has developed over a long period of time, what implications it carries for clinical practice, and what directions might be taken in future research.

6.1. What Has Been Learnt from the Process?

Perhaps one of the most powerful lessons to emerge from this research is the extent to which institutional mechanisms shape family dynamics. The analysis confirmed psychoanalytic theories of sibling rivalry (Mitchell, 2003; Coles, 2003) but also extended them by showing how institutional practices, such as waiting lists, can actively re-produce feelings of rivalry and exclusion. This highlights the fact that sibling inequality is not merely a component of the internal world, but one that can be co-constructed by external social and institutional frameworks.

The research also illuminated the invisible weight borne by parents and kinship carers. Their accounts revealed the multiple and often conflicting roles they inhabit: — parent, advocate, containers of children’s distress, and negotiator with services. Such multiple roles have the potential to blur their sense of identity and leave little space for their own needs. This echoes how systemic failings can intensify the burden of care.

Another finding to emerge from the research was how past traumas could resurface in the present. Waiting lists were rarely experienced as neutral spaces. Instead, they had the potential to reopen earlier wounds of abandonment, neglect, or inequality. Families’ stories showed how a current experience of exclusion could become entangled with histories of loss and abandonment. This finding adds to psychoanalytic understandings of trauma – not only by highlighting its compulsion to repeat – but by situating it within institutional silences.

Finally, the research taught me something about the power of recognition in the waiting space. Participants strongly conveyed how even a small symbolic act — a letter, a phone call, an acknowledgment of existence — would have made a significant difference to their sense of wellbeing. This speaks to the psychoanalytic idea that being “held in mind” is fundamental

to psychic equilibrium. Recognition of a waiting sibling does not always require radical systemic change. Parents and carers suggest it can begin with simple gestures like a letter or card which simply affirms the existence and value of the child outside the therapy room.

6.2. What Might Have Been Done Differently?

Looking back, there are several ways in which the study might have been developed further. A key limitation is the absence of siblings' own voices. While parents and carers provided invaluable insights, the direct perspectives of children on waiting lists remains missing. This would have required additional ethical approval from an independent research ethics committee, consent from a responsible adult and assent from the child. However, including these voices might have deepened the analysis and challenged adult interpretations of children's behaviour.

A larger or more diverse sample would also have allowed for a deeper exploration of differences across cultural, socio-economic, and service contexts. Since this study was situated in one CAMHS setting, the findings are shaped by the particular practices and pressures of that service. Comparative studies across multiple sites could have highlighted systemic patterns more widely.

Methodologically, I might also have considered incorporating longitudinal interviews to capture how family dynamics shift over time. Waiting is not a static experience but an evolving one, and families' narratives of exclusion or recognition may change over time. Despite these limitations, I believe the chosen methodology of IPA captured the depth and

richness of lived experience, even if it inevitably involved trade-offs in scope and generalisability.

6.3. Relationship to the Research Question

The central research question asked about the impact of CAMHS-based psychoanalytic psychotherapy on sibling relationships when one child is in treatment and another is left waiting. The findings answer this question by showing that the experience of unequal access intensifies feelings of rivalry, invisibility, and envy among siblings. For waiting children, the absence of recognition can even lead to distress expressed through somatic symptoms such as panic attacks and attempted suicide. For siblings in therapy, the privileged access to a therapist was sometimes won as a badge of superiority, further straining relationships.

The research also showed how sibling dynamics cannot be disentangled from their parents and carers. The burden of care, guilt, and blurred identities experienced by these adults shaped how sibling inequalities were managed within the family. Thus, the impact of CAMHS psychotherapy on siblings is not only a matter of sibling dynamics but of broader family and institutional systems. In this sense, the findings suggest that the CAMHS system does not merely reflect sibling dynamics but can actively participate in their repetition. Waiting lists are not just neutral cogs in a resource allocation wheel but symbolic enactments of exclusion that can profoundly shape sibling relationships.

6.4. Implications for Practice

Several implications for practice arise from these findings. First, CAMHS services must acknowledge the existence and needs of waiting siblings. Even when resources are scarce, symbolic gestures of recognition — letters, check-in calls, opportunities for brief contact — can help mitigate feelings of invisibility and exclusion. Recognition does not require extensive resources but rather an attunement to the psychological meaning of waiting.

Second, services should pay greater attention to the burden placed on carers. Parents and kinship carers are often stretched to breaking point, balancing the needs of multiple children while managing their own feelings of guilt and exhaustion. Support structures for carers, whether through groups, psychoeducation, or systemic interventions, are essential to prevent them from becoming unacknowledged casualties of the process.

Third, clinicians should consider how institutional practices may unconsciously reproduce sibling dynamics. Therapists working with one child *inside* the therapy room need to be mindful of how their presence is perceived by siblings waiting *outside*. The therapeutic frame itself – with its requirement of regular time and space - also has an impact on family dynamics when carers are stretched to the limits juggling schedules for multiple children. Sensitive reflection is therefore required by clinicians in order to prevent CAMHS from unintentionally enacting the same feelings of deprivation and inequality it seeks to repair in relationships. A system of ‘Sibling Triage’ – like processes which operate in UK schools - could be considered within CAMHS systems to recognise the shared experience of brothers and sisters - particularly among those who have lived through the same, significant traumas.

Overall, the findings highlight the importance of sensitive practice that recognises how waiting lists can trigger trauma in families. Services must continually consider the histories

that families bring with them and avoid compounding earlier wounds through silence or neglect.

6.5. Suggestions for Future Research

This study opens up several avenues for future research. One key direction is to include the voices of siblings themselves. While carers' accounts are valuable, they cannot substitute for the lived experiences of children who wait. Engaging with siblings directly could explore how exclusion is felt and managed by young people themselves.

Future studies could also compare different CAMHS sites or different therapeutic modalities to explore whether similar dynamics emerge across contexts. Cross-cultural research would be particularly valuable, as sibling relationships and perceptions of fairness are always embedded in and often shaped by cultural expectations.

Another fruitful avenue would be intervention-based research. Pilot schemes such as sibling waiting acknowledgement letters, phone calls, or support groups could be trialed to assess their impact on mitigating feelings of rivalry and exclusion. Such studies could help services develop practical strategies for addressing the needs of waiting siblings.

Finally, more theoretical work is needed to extend psychoanalytic thinking into the institutional domain. While psychoanalysis has often focused on intrapsychic and familial processes, this study suggests that institutions themselves can act as agents of rivalry and trauma. Developing a psychoanalytic theory of institutional dynamics in relation to siblings may help clinicians better understand the wider contexts in which they practice.

6.6. Final Reflections

Conducting this research has been both challenging and deeply rewarding. It has required me to hold multiple perspectives in mind: the voices of families, the demands of theory, and my own position as a clinician and researcher. Meanwhile, as someone who previously worked as an investigative journalist, I had to re-invent a wheel of research practice I had learned over 25 years and accept feelings of frustration and vulnerability in the process.

As well as grappling with changes in methodology, the process also stirred strong countertransference feelings — frustration at systemic failings, sadness at families' pain, and empathy for the siblings left unseen. These reactions needed to be reflected upon but deepened my understanding of the issues being highlighted.

Ultimately, this thesis highlights the profound consequences of how services allocate care. Sibling relationships are not marginal concerns but central to every child's sense of identity, belonging, and recognition. When one sibling is privileged and another is left waiting, the psychological costs are borne not only by children but by whole families.

I hope these findings may provoke CAMHS, and mental health services more broadly, to reflect on how their structures might inadvertently reproduce the very inequalities and traumas they aim to heal. In bringing these hidden dynamics to light, I hope this research also contributes to a broader conversation about the ethics of waiting. Perhaps most powerfully, this study is a reminder that in contexts of austerity and scarcity, recognition matters more

than ever. To be seen, held in mind, and acknowledged as worthy of care is not a luxury but a necessity for psychic survival.

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Appendices

Appendix 1

From: HENDRY, Sharon

Sent: 02 October 2023 12:51

To: xxx Cc: xxx Subject: My Research Journey Begins

Dear Psychotherapy Colleagues,

With the support of so many of you, I've survived the training so far and now my doctoral research has been approved to begin.

I've attached the formal recruitment letters but wanted to reach out to you all personally to ask if you could think of any appropriate potential participants in your caseload.

The title is: GHOSTS IN THE WAITING ROOM: What can be learned from understanding the impact of psychoanalytic psychotherapy on biological sibling relationships when one child is in treatment and others are on the waiting list? A qualitative study of parents' perspectives.

This means I am looking for 4 parents (the main carer who brings the child to CAMHS) who are willing to talk to me about what they've observed since one child has been in treatment and their other child has been waiting.

Other criteria as follows:

- They will be invited to reflect on their thoughts/ feelings after their child has been in treatment for at least one year.
- Ideally, the interviews will take place face-to-face in the Bromley clinic.
- The siblings should be biologically related.
- The siblings should not have physical disabilities or be neurodiverse (this is to rule out an area of sibling dynamics which is already well-researched).

Please do let me know if anyone springs to mind.

With Gratitude

Sharon

Appendix 2

CAN YOU HELP ME FIND A PARENT!

I'm studying the impact on siblings when one is in treatment
and one is waiting.

I need to interview parents about their observations.



KEY CRITERIA FOR RECRUITMENT:

- No physical disability or neurodiversity
(to rule out an area of sibling dynamics already well-researched)
- Sibling in treatment for at least 3 months
- Siblings should be biologically related
- Waiting sibling open to CAMHS or in a referral process
from another source ie. [REDACTED]
- Waiting sibling can be open/referred for any treatment

Thanks so much, Sharon
Trainee Child Psychotherapist | sharon.hendry2@nhs.net

Research Project Information Sheet

You have been given this information sheet to invite you to take part in a research project. This information sheet describes the study and explains what will be involved if you decide to take part.

Study Title: GHOSTS IN THE WAITING ROOM: *What can be learned from understanding the impact of CAMHS-based psychoanalytic psychotherapy on biological sibling relationships when one child is in treatment and others are on the waiting list? A qualitative study of parents' perspectives.*

What is the purpose of this study?

I am interested in hearing about the lived experiences of parents when they have one child in treatment and others are on the waiting list. Through your own experience, I want to explore what happens to sibling relationships when one child is receiving CAMHS-based psychotherapy treatment and one child is waiting to access it.

I am interested in whether the data I collect during my research could make a case for triaging siblings on CAMHS waiting lists, given that many have endured similar experiences and are living in the same family systems.

Triage is currently based on current risk and circumstances with no special consideration given to siblings living in the same household. This is in contrast to the UK education system which – while not comparable to CAMHS in its purpose – does appear to hold siblings more in mind. Most admissions criteria give priority to children who already have siblings in school – indicating a recognition of a need for continued shared experiences.

Who is conducting the study?

My name is Sharon Hendry.

I'm a researcher working for xxxxxxx and training to be a Child and Adolescent Psychotherapist in xxxxxx. This project is being sponsored and supported by The Tavistock and Portman Centre and has been through all relevant ethics approval (TREC). This course is overseen and certified by The University of Essex.

What's involved? Explanation: purpose of and background to research

The study sets out to examine the impact of CAMHS-based psychotherapy on sibling relationships when one child is accessing treatment and others remain on the waiting list. It will do this by studying parents' views. 4 parents who are able to reflect on a period of at least 3 months of their child's treatment will be interviewed by me.

The specific aims of the proposed research are as follows:

Appendix 4

Semi-structured interview schedule for parents of biological siblings who have waited for CAMHS treatment while another sibling is already in treatment

Title: GHOSTS IN THE WAITING ROOM: *What can be learned from understanding the impact of CAMHS-based psychoanalytic psychotherapy on biological sibling relationships when one child is in treatment and others are on the waiting list? A qualitative study of parents' perspectives.*

Welcome: Explanation of it being a semi-structured interview lasting up to 60 minutes. Remind parents they are welcome to talk freely about the topic of siblings dynamics while in and out of CAMHS treatment and discuss anything they might feel is relevant to the study.

Experience of CAMHS to-date:

- How is your experience of the CAMHS referral process to date? Why and how was your child initially referred?

Early impressions of the impact of CAMHS on the sibling dynamic:

- How was the impact of the initial assessment on both the first sibling to access CAMHS and the one who was left waiting? How do you feel about it and how do you make sense of this?
- How was the impact on both the sibling accessing treatment and the sibling waiting when psychotherapy began?

Parental experiences of the CAMHS treatment:

- How was your experience of managing the journey to CAMHS and the waiting room? Did you have to leave another sibling at home for example, or keep them in the waiting room with you? How did that feel for you and your children?

Siblings' experiences of the CAMHS treatment:

- What different behaviours – if any – did you notice in your individual children (the one in treatment and the one waiting) as the therapy was in progress? How did you make sense of this?
- How was the quality of the relationship between siblings as the therapy was in progress? Did it differ to you from before treatment began?

Ending the CAMHS treatment:

- How did both children experience the ending of the therapy in CAMHS and the aftermath?
- How did the experience of one sibling being treated in CAMHS impact on family dynamics overall?

Future:

- What could CAMHS do differently in future to help siblings who wait?

Final thoughts:

- Anything not asked but would like to mention?
- Thank them for taking part.
- Any questions or want any further information to contact me.

- Signpost them to their care co-ordinator if they need support following the interview discussion. Send debrief out to them.

Appendix 5

Quality Assurance & Enhancement Directorate of Education & Training Tavistock Centre
120 Belsize Lane London NW3 5BA

Tel: xxxx

<https://tavistockandportman.nhs.uk/>

Sharon Hendry

By Email

09 January 2024

Dear Sharon,

Re: Research Ethics Application

Title: 'GHOSTS IN THE WAITING ROOM: What can be learned from understanding the impact of CAMHS-based psychoanalytic psychotherapy on biological sibling relationships when one child is in treatment and others are on the waiting list? A qualitative study of parents' perspectives.'

I am pleased to inform you that the Trust Research Ethics Committee formally approved your application on 11 October 2023.

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.

If you have any further questions or require any clarification do not hesitate to contact me. I am copying this communication to your supervisor.

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

Yours sincerely,

Michael Franklyn

Academic Governance and Quality Officer T: xxxxx

Email:

cc. Course Lead, Supervisor, Research Lead

Appendix 6**CONSENT FORM**

Project title: GHOSTS IN THE WAITING ROOM: *What can be learned from understanding the impact of CAMHS-based psychoanalytic psychotherapy on biological sibling relationships when one child is in treatment and others are on the waiting list? A qualitative study of parents' perspectives.*

Name of researcher: Sharon Hendry

Please initial the statements below, in the relevant box, if you agree with them:

- I _____ voluntarily agree to participate in this research project.
- I confirm that I have read and understood the information sheet for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.
- I understand that this research is part of a degree
- I understand that my participation in this study is voluntary and that I am free to withdraw, without giving a reason, at any time up to three weeks after the completion of the interview.
- I understand that the interview will be digitally recorded and transcribed as described in the participant information sheet.
- I understand that the information I provide will be kept confidential, unless I or someone else is deemed to be at risk.
- I understand that direct quotes from the audio recording may be used in this research study but will be made anonymous to the reader and held securely by the researcher.
- I understand that as the sample size is small this may have implications for anonymity, as person who knows me might be able to identify me
- I understand that the results of this research will be published in the form of a Doctoral research thesis and that they may also be used in future academic presentations and publications.

Contact details:

Researcher: Sharon Hendry Email: xxxx

Supervisor : Dr xxxx Email: xxxx

Participant's Name (Printed): _____

Participant's signature: _____ Date: _____

Appendix 7

Experiential Statements	Main Text	Exploratory Notes
SHUT OFF OUTSIDE TO THINK INSIDE	<p>1. <u>MUM SARAH & SIBLINGS:</u> <u>ADRIAN (trans male), 16, &</u> <u>MICHELLE (female), 12 –</u> <u>INTERVIEW 1</u></p> <p>2. Interviewer: Hi Sarah</p> <p>3. Sarah (moving into a room): Sorry. I'm just coming from the shops. Ok, it's going to be quiet here. Sorry you're in my bedroom. There we go. Alright, so I'm just gonna shut my window so it's not too noisy. There we go.</p> <p>4. Interviewer: Alright, ok. How's your bank holiday been?</p>	<p><i>Busy mum on-the-go. Needs to shut herself away and seek privacy. Wants peace and quiet. Shuts outside world out in order to think about what is inside?</i></p>

Appendix 9



Appendix 10



Appendix 11

Table of Personal Experiential Themes 1

Theme 1: Parent pulled between siblings

(This theme is about polarisation; the experience of this mum being pulled in opposite situations/emotions/behaviours. A sense of closeness and distance, which seems to overshadow what's in the middle.)

Experiential Statement	Page/Line	Quote
Sibling in the dark	P9	It was kind of like she wanted to know what the hell was going on.
One sibling at a time	P8	I've got a lot of very good friends in the area and they would just take her off for me, so I could concentrate on Adrian, but that has been a feature of the last 5 years.
Sibling shielded from not knowing	P8	She didn't really understand and I kind of shielded them from that.
Same experience different treatment	P23	I need a therapist. It happened to me too, you know.
Sibling injustice	P24	It happened to them too, so why wouldn't they get the same attention?
Sibling differences are impactful	P11	So they're very different people. I will say that first for the start, and that has an impact.
Together but apart	P15	So they're in therapy at the same time, but separately.
Sibling tension	P23	They wouldn't talk to each other but Michelle would say a lot to me.
Sibling disconnect	P18/19	So then there's that disconnect.
Hidden needs	P40	'Please stop asking about Adrian. It's lovely that you give a shit but at the same time, my daughter is stood

Appendix 12

<u>Database Name</u>	<u>Search Name</u>	<u>Results</u>
<u>Psych Info</u>	(siblings OR brother OR sister) AND (psychoanalysis OR psychotherapy)	1398
	wait*	25,266
	(siblings OR brother OR sister) AND (psychoanalysis OR psychotherapy) AND wait*	21
<u>PEP Archive</u>	(siblings OR brother OR sister) AND (psychoanalysis OR psychotherapy)	19,294
	wait*	16,374
	siblings OR brother OR sister) AND (psychoanalysis OR psychotherapy) AND wait*	6,829
<u>PEP Archive Filters Applied</u>	Linked Full Text Article Book Book Extract Report Review	6,564