The interrelationship between brain, mind, and relational experience: Psychoanalytic work with families attending Under-5 CAMHS for help for their potentially autistic child.

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Abstract

Objectives

The study sought to explore the research question: What do psychoanalytically informed Early Childhood Mental Health Specialists (ECMHS) in an under-5 CAMHS service offer in their parent–child work with autistic children and those under consideration for autism. What are the opportunities and barriers in their work with families and the professional network that shape how they can use their understanding of the interrelationship between brain, mind and relational experience.

Methods

Five ECMHS from the same team were interviewed using semi-structured interviews. Interviews were transcribed and analysed using reflexive thematic analysis (RTA).

Results

The findings highlight a contrast in how 'expertise' is perceived between ECMHS and professionals, such as doctors, who assess and diagnose autism and are often viewed as holding the authority, impacting how ECMHS offer their unique expertise and experience to multiagency discussion and work with children presenting with autism/possible autism. An over-focus on behavioural/diagnostic models for understanding may reflect both individual and societal defences against thinking more deeply about the emotional life of infants and young children, and their relational context. The study identified a number of barriers to working with the emotional relationship between parents and children, which often stem from parents who have experienced complex infancy and early lives themselves, shaped further by class, socio-economic status, impact of race, culture, language and the current systemic context.

ECMHS offers sensitive and nuanced work with parent-child dyads, drawing on psychoanalytic theory both in understanding and in practice. Their approach seeks to understand at a deeper level unconscious processes and relational dynamics and modes of functioning, which consider the complex lives and histories that influence this. In doing so, they aim to support parents (and professionals) to engage more deeply with the emotional and relational world of the infant/young child and parent(s) to bring about change, as opposed to focusing on behaviour and strategies.

Conclusions

This study highlights the importance of recognising the interrelationship between brain, mind and relational experience, central to all development and considered in the context in which autistic traits and diagnostic concerns emerge. Key findings from empirical research support the findings from this study regarding the efficacy of early intervention into the parent-child relationship. It draws attention to the defences against thinking, at individual and systemic levels that sit within the current social, political, economic and cultural climate, where I would argue there is a societal leaning towards abstracted, surface-level understandings of experience rather than in-depth exploration.

ECMHS offer a psychoanalytically informed approach, which provides an important framework for supporting development in vulnerable dyads, particularly through intersubjective experience, in which autism presents. In a period of limited resources and increasing reliance on diagnosis as a gateway to support, this study argues for the recognition of relational work as essential to infant/young child mental health and broader public health.

Key words Early childhood mental health specialists, Psychoanalytic theory, Infant mental health, Young child mental health, Autism, Diagnostic models, Early intervention, Infant development, Intersubjectivity

1. Introduction

The study explores the complex work of early childhood mental health specialists (ECMHS) - a pseudonym to protect confidentiality, who are the professionals that make up this CAMHS under 5 service. ECMHS offer a variation of a service that can be found nationwide, which is often Child and Adolescent Psychoanalytic Psychotherapy (CAPP) led (delivering parent-infant psychoanalytic psychotherapy). They are unique to this area in that they are the only CAMHS team across the age range who work specifically using a psychoanalytic theoretical framework, although they are not CAPPs. There are some CAPPs in the team, but they were deliberately excluded from this study as it was judged important to identify how a wider workforce, not just those qualified CAPPs, can deliver this specialist work. The team are highly experienced professionals from diverse backgrounds, including nursing, health visiting and psychodynamic psychotherapy. All have completed pre-clinical training in infant observation to postgraduate diploma or master's level, which is a prerequisite for the role. They approach their role with the understanding that the relational, social, and emotional context surrounding the infants and young children they work with is central to recognising their needs and shaping the interventions they provide.

They work with children who either have a diagnosis of autism or where one is being sought as an explanation for the difficulties being experienced for this child and their family. The study aims to explore how these professionals are able or not to bring their unique perspective, clinical understanding and approach to a 'problem' identified in children and their families that are often complex and multifaceted, but where there is a pull towards diagnosis in isolation. There are two important relating problems that arise from this and which are central concepts under examination in this study.

Firstly, how early relational trauma can either give rise to presentations in young children that closely resemble those associated with autism, or neurodevelopmental sensitivity might coexist with and complicate a relational struggle, creating challenges for understanding and assessment. Secondly, how once a diagnosis of autism is made, curiosity about the child's social and emotional environment might be reduced, with difficulties often assumed to arise solely from neurodevelopmental factors. This highlights a broader and often implicit assumption that the social and emotional difficulties associated with autism are not responsive to therapeutic (relationally focused) intervention.

These challenges are further compounded by the barriers and defences that can arise against thinking about the relational, social and emotional worlds of these children, not only within families and professional networks, but also through the influence of wider systemic forces. Cultural and societal tendencies to individualise what may be fundamentally relational or social problems, such as early relational trauma and challenges, shape how difficulties are understood. At the same time, limited resources and constrained service provision create additional pressures that restrict the capacity for reflective, nuanced work. The study seeks to explore how psychoanalytically informed perspectives might contribute to a deeper understanding of these children's needs and the contexts in which they develop, including the interrelationship between the brain, mind and relational experience.

I became interested in this research idea when working therapeutically with such children as a trainee CAPP. For example, a young child who was presenting with autistic traits, but their infancy and early relational experiences were complex, was given a diagnosis aged four. Over the course of long-term psychotherapy, which coincided with parents receiving more support and the education provision improving, the autistic traits appeared to reduce significantly. In a wider sense, this tension regarding diagnosis and children with complex histories is something I have encountered often both as a therapist and in my previous role as a social worker. This prompted my wish to explore further the use of psychoanalytically informed approaches both in sense-making and formulation, and in intervention with these children.

Finally, it is important to acknowledge the highly sensitive nature of these discussions in both the professional and popular literature and the importance of the use of language and in particular, terminology. Autism has been referred to in a number of ways over the years, and in research, this remains highly inconsistent. Some call it an Autistic Spectrum *Disorder* (ASD), however more recently this has shifted to a *Condition* (ASC) to take into account that it is a different way of being, rather than a disorder (i.e. something 'wrong'). Unless directly quoting an author's writing, or when there is a need to be more specific, I will use the term *autism* to encompass the full spectrum of the condition. Finally, when discussing parent-infant/young child work, often authors refer to the *mother.* I will endeavour to use the term *parent*, although may use the term *mother* when directly referencing literature or when I am specifically referring to the mother. I use the term parent-child to represent all children under the age of 5, as this service is concerned with, however, there are times that I am speaking either more specifically about infancy, so will refer to parent-infant or referring to official titles such as 'parent-infant psychoanalytic psychotherapy'.

2. The parent-infant: Important context

In the field of early childhood mental health work there are three considerations - the infant/young child, the parent (often the mother) and their relationship.

The beginning of life sets in motion the early establishment of internal, psychic life and object-relations that hold significance throughout the life course.

"… the new-born baby experiences, both in the process of birth and in the adjustment to the postnatal situation, anxiety of a persecutory nature. This can be explained by the fact that the young infant, without being able to grasp it intellectually, feels unconsciously every discomfort as though it were inflicted on him by hostile forces. If comfort is given to him soon—in particular, warmth, the loving way he is held, and the gratification of being fed—this gives rise to happier emotions. Such comfort is felt to come from good forces and, I believe, makes possible the infant's first loving relation to a person or, as the psychoanalyst would put it, to an object. My hypothesis is that the infant has an innate unconscious awareness of the existence of the mother".

(Klein, 1959).

Klein's early observations and hypothesis are foundational to our understanding of infant development. She highlights the profound impact of the experience of coming into being, both physically and psychologically. Birth is a momentous event for all involved. She recognised that infants possess innate relational capacities and that development, from the moment of conception, unfolds in connection with another—most immediately, the mother. The trajectory of a new life is shaped by this relational context, beginning with the mother who carries and births the infant, and continuing through subsequent key relationships.

Contemporary research in prenatal and postnatal development lends empirical support for and adds to these early psychoanalytic insights, especially in the development of understanding about the profound impact of in-utero experience. Studies have demonstrated that new-borns can distinguish and show a preference for their mother’s voice (Field, 2007), suggesting that relational awareness begins before birth. Piontelli (1992) further observed that behavioural patterns evident in utero often persist after birth, indicating a continuity between prenatal experience and postnatal development.

It is now widely accepted that infants do not enter the world as blank slates but instead are active contributors to intersubjective relating from the beginning. Their development is shaped by the maternal environment, which includes the mother’s physical health, psychological wellbeing, and social circumstances. The infant’s own temperament, along with findings from the field of epigenetics (Music, 2017), reveals the complex interplay between genetic predispositions and environmental influences. Nature and nurture are deeply interconnected and cannot be meaningfully separated (Waddell, 2002).

Maternal exposure to chronic stress, such as domestic violence, poverty, and social isolation, as well as harmful behaviours like substance use, can have a significant impact on foetal development. Maternal mental health, particularly elevated cortisol levels, affect the infant’s capacity for stress regulation in utero (Zietlow et al., 2019). These influences are often shaped by intergenerational patterns of trauma and familial legacy. Issues around maternal health in pregnancy, traumatic birth and early infant illness are also important factors in shaping infant development.

In addition to these biological and environmental factors, the infant is affected by the parents’ conscious expectations and unconscious emotional life. Their internal object relations, projections, and anxieties all contribute to the quality of the holding environment provided, which Winnicott (1960) described as central to the emergence of the self.

Motherhood, though nearly universal, is experienced in deeply personal and varied ways. It's very ubiquity often leads to the transition being underestimated, by society and sometimes by mothers themselves. The gap between idealized expectations and lived reality can be jarring. Routine tasks like feeding and sleep, seemingly mundane, can become emotionally fraught and unexpectedly difficult. These struggles may trigger intense primitive anxieties and attachment wounds, stirring feelings of anger, guilt, inadequacy, or failure that are hard to bear and may be unconsciously projected onto the infant—expressed in thoughts such as "you don't love me" or "you are a difficult baby". Social pressures from family, friends or the absence of nurturing role models can intensify the emotional toll. The parental relationship can become very strained and single mothers must bear the demands alone, with little reprieve from the intensity.

As many as 20% of new mothers will experience mental health conditions ranging from mild to severe depression, anxiety, psychosis and PTSD (NHS, 2018) anduring the first-year post-partum, suicide remains the leading cause of maternal death (Tubb, 2021).

The Association of Child Psychotherapists (ACP) Response to the Health and Social Care Committee Enquiry into the First 1001 Days of Life (2018) highlights the need for a joined-up strategy in service provision for the most vulnerable parent-infant dyads, recognising the critical importance of the prenatal and postnatal developmental stages up to age two for long-term outcomes. It sets out the argument for the significant and essential contribution that the psychoanalytic framework can offer, particularly through its CAPP members. While ECMHS practitioners are not CAPPS, they have all trained to the pre-clinical level in psychoanalytic infant observation. This means they draw on the same psychoanalytic and developmental frameworks that inform CAPP parent-child psychotherapeutic work, making their contribution to this field also important and necessary, although the parameters of their work might vary.

Importantly, ECMHS focus not solely on the parent's mental health, as is often the case in traditional perinatal mental health services, but on the infant or young child's development within the context of the parent-child's relationship. The inextricability of the infant from the parent in their coming into being (and in their subsequent development as an individual) is well established in both psychoanalytic and developmental fields; hence the importance of working with the dyad to support the welfare and development of infants or young children who may be struggling. ECMHS focus specifically on these more vulnerable dyads, where significant disturbance within the parent, the infant/young child, and the relationship between them is usual and forms the backdrop to the many defences in place that create barriers to thinking about the relationship.

A diagnostic approach that focuses on the infant or young child in isolation risks overlooking trauma that remains unacknowledged within the system, particularly in the parent/s. These parents are often excluded from the diagnostic process entirely. Lyons-Ruth's (2007) research, which centres on the most disturbed dyads where disorganised attachment manifests, emphasises the core role of inter-subjectivity in infant development. She notes that when this functioning is organised within families marked by "intense and survival-related affects that become established and inter-generationally transferred, it shapes intersubjective experiences within a localised relational realm but also in the forming of societal structures" (p. 605).

The parent-child experience sits within its wider environmental context; therefore, the impact of racism, culture, class and socio-economic disadvantage and how these intersect, are important and relevant factors that affect the experience of these dyads and in terms of how they access and make use of this kind of service.

3. Literature review

3.1 Introduction

In addressing the research question I sought to underpin this research project with relevant theoretical, empirical, and clinical literature. I had several aims in approaching the review of this literature. I wanted to deepen my understanding of autism in terms of aetiology and manifestation, from both medical/organicist and psychoanalytic perspectives. Alongside this I wanted to understand the interrelationship between brain/mind and relational experiences, and its relevance to both autism and development in general. This meant exploring the relevant developmental neuroscience research but also the links this has with psychoanalytic ideas about the development of mind and thinking. Central to the research question is the role that early relational experience has on development. Therefore, I examined current research on early relational interventions for autism, alongside psychoanalytic approaches with consideration of how medical/organicist and psychoanalytic perspectives converge or diverge in the context of early parent–child intervention.

This study is concerned with complex experience and development, regardless of the presence of autism. Within this scope, I aimed to explore the role of early attachment experiences, the impact of trauma, and the psychoanalytic and developmental psychology fields, that inform understandings of the development of self in the parent–infant/young child dyad, with particular attention to research into and informing Psychoanalytic Parent–Infant Psychotherapy (PPIP) interventions, which underpins much of ECMHS's work.

3.2 Literature review methodology

To identify relevant literature, I conducted searches across multiple databases including PsycINFO, PEP Archive and Google Scholar, as well as targeted searches within specialist journals such as the *Infant Mental Health Journal* and the *Journal of Child Psychotherapy*. Boolean operators (e.g., "AND," "OR") were used to refine searches, with terms such as "autism AND psychoanalysis," "early intervention AND autism," "trauma AND autism diagnosis," and "parent-infant therapy AND autism. Inclusion and Exclusion criteria were set to ensure the relevance and quality of the sources. Only peer-reviewed empirical studies and theoretical papers available in full-text format and in English were included, as this allowed for a more thorough engagement with the material. Given the psychoanalytic orientation of the study, I did not restrict the literature by publication date, although I anticipated that the most relevant empirical studies would be from the 21st century.

I combined both systematic and narrative approaches. Although I did not explicitly divide the review into these categories, I aimed to tell the story of the research in a way that reflected the evolving understanding of the topic (Popay et al., 2006). As the review progressed, it became clear that a narrow focus on autism risked excluding important insights into typical developmental processes and I therefore considered a purely systematic review to be limiting. While systematic methods provide rigour, they are constrained by the terms and categories they rely on. In this case, those constraints risked reinforcing the very issue identified by participants: that once autism is diagnosed or even suspected, ordinary development is often deprioritised or treated as irrelevant. As a result, I intentionally incorporated relevant studies identified through reference lists and citation tracking, recognising this as a necessary and explicit methodological step.

Snowballing was therefore used as a deliberate complement to database searches to address the limitations of predefined terms, which were unlikely to capture key literature on ordinary development. To minimise bias and avoid 'cherry-picking', consistent inclusion and exclusion criteria were applied to all sources, regardless of how they were identified. Study selection ensured that the inclusion of literature on ordinary development was systematic, justified, and aligned with the research aims.

Explicitly integrating literature on ordinary development was an important conceptual position identified in the research, as it reflected in the distinctive stance ECMHS take in holding both autism-specific knowledge and an understanding of typical (relational) development in mind simultaneously. In doing so, highlighting the important need for attention not to shift away from ordinary developmental processes, but rather towards recognising and supporting the often subtle yet meaningful capacities that can and do emerge despite the presence of autism.

Finally, this literature review is situated within a reflexive thematic analysis (RTA) framework (Braun & Clarke, 2022). Although it was the first chapter I drafted, the largely inductive nature of the data analysis ensured that the literature did not predetermine the findings. At the same time, the need to draw on a deductive lens when identifying relevant literature on typical developmental processes meant that the review evolved iteratively as my analysis progressed.

3.3 Autism – what is it?

Kanner (1943) in his seminal research first identified the condition and suggested autistic children "have come into the world with an innate inability to form the usual, biologically provided affective contact with people" (Hobson, 2002: p. 10). The modern definition is that autism is considered a lifelong neurodevelopmental condition (Spikol et al. 2019), with approximately 1 in 57 school age children having a diagnosis (Roman-Urrestarazu at. al, 2021). It is a condition marked by differences and impairments in reciprocal social interaction and social communication, combined with restricted interests and rigid and repetitive behaviours (NICE 2011: 1.5). The American Psychiatric Association (2013) described it as a set of neurodevelopmental conditions characterised by the early presence of difficulty in social interaction, non-verbal communication and reciprocity, restricted, repetitive patterns of behaviour, interests, or activities as well as hyper or hypo sensory reactivity.

Recent research suggests that autism aetiology is a combination of polygenic genetic predisposition, with different genetic pathways responsible for the severity of symptoms (Satterstrom at al., 2020). In their evidence-based review of systematic review and meta-analysis, Modabbernia et al. (2017) cited potential associations with prenatal and perinatal conditions including parental age, birth complications in labour and birth including infant hypoxia and needing to be resuscitated, as well as potential links with caesarean-section under general anaesthetic and maternal obesity and diabetes; although they also identified significant methodological limitations to studies on environmental risks factors relating to autism.

Lord et al. (2020) provide a comprehensive multidisciplinary review of autism spectrum disorder, drawing together evidence from genetics, neuroscience, developmental psychology, epidemiology, and intervention research. The review highlights the diversity of autism, noting strong but complex genetic influences, subtle neurobiological differences, and diverse developmental trajectories that begin early in life. They do also broadly summarise evidence for psychosocial and behavioural interventions, emphasising that early support can improve social communication and adaptive functioning, although long-term outcome data remain limited. Although, despite the review's acknowledgement of the role of social and environmental factors in intervention, there is limited attention paid to how these environmental factors interplay with the condition's development more widely. Research increasingly highlights the complex interaction between nature and nurture—perhaps better understood as genes taking their "cue from nurture" (Ridley, 2003) or "nature via nurture" (Raphael-Leff, 2007). However, there remains a strong pull in research to treat them as separate entities, reflecting the either/or dichotomies that continue to shape attitudes to making sense of behaviour and difficulty through diagnosis.

Historically, organicists and psychoanalysts have been at odds over the condition and its aetiology. The psychoanalyst Bettelheim's (1967) now debunked view of the 'Refrigerator Parent' suggested it was the consequence of cold and detached mothering. Contemporary psychoanalytic perspectives understand autism as both an organic condition (Spoladore 2013) but also identify "autistic modes of functioning" (Klauber and Rhode 2004: 264) that may promote or hinder the development of an autistic child and their autism presentation.

Holloway (2022) refers to the three axis of autism: genetic (nature), trauma (medical, cumulative, transgenerational, parent) and environmental (nurture) and maintains that psychoanalytic literature largely suggests the presence of all three axes in all cases of autism. Alvarez (1992; 2016), who argues that psychoanalysts and organicists agree on much regarding causation, also draws attention to how impaired neurological functioning could impact negatively both on the infant's ability to make use of the early care they receive and the potential consequence that their atypical ways of relating have for the parents' responses to their infant. This can result in the development of more defensive/coping mechanisms, and an amplification of such interactions may lead to an ever-increasing lack of connectedness between them (2016). What Alvarez refers to as the "awesome power of an effect to become a cause" (1992: p. 187).

Tustin (1992) refers to the trauma of a genetically susceptible, sensitive infant's sudden and premature realisation of their separateness from their maternal object, which is at the root of what she has termed 'psychogenic autism'. Tustin (2008) distinguishes *psychogenic autism* from *organic autism*, defining it as the result of damage to the psyche rather than neurological. She describes this as occurring when highly sensitive infants experience a sudden, premature, and unbearable realisation of separateness from the maternal object, leading to protective and defensive responses.

Developing Tustin's work Mitrani (2010) writes "[when an] infant experiences (what is for him) too great a gap between himself and a now suddenly separate mother, he may protectively and perhaps reflexively withdraw into his own disconnected sensual experience" (p. 244). Auto-sensuous protections serve to avoid co-operation and reciprocity as these indicate separateness, and a protective shell that guards against unbearable sensations (Tustin, 1992). This over development of auto-sensuousness Tustin suggests blocks normal sensuous experience *with* others. Instead, a state of fusion takes places as a defensive response to the reality of this separateness, thus leaving no 'space between' for object-relations to develop through normal processes of projection, introjection and projective identification.

Successful processes of projective identification are key to healthy infant development. The infant can evacuate unmanageable emotional states into a receptive parent whose capacity for reverie means that they can take in, hold, and make sense of the infant's projections, meaning these raw emotional experiences can be transformed. This is the basis of Bion's (1962b) concept of containment, in which the caregiver's alpha-function converts unprocessed sensory and emotional "beta-elements" into "alpha-elements" that can be thought about, stored, and used for meaning-making. Through this process psychic pain is diminished, creating the earliest conditions for thinking to develop because as this process is repeated over time, the infant internalises the function of containment and gradually develops a mind of their own, capable of generating thoughts rather than being overwhelmed by experience. This is the basis of what Bion (1962b) refers to as the K link, namely the drive for knowledge about oneself and others and the ability to turn raw experience into meaningful knowledge, which sits alongside the capacity for *negative capability* (Bion, 1970); the ability to stay with uncertainty and not know The is in opposition to – K, which is the drive to mis-know or avoid painful truth, perhaps through fear of its catastrophic consequences.

These developmental processes can be significantly challenged in some autistic infants and children. As Rhode (1989, 1997) notes, autistic children may “deal in surfaces” and struggle to engage in projective identification or to take in the caregiver’s transformed emotional experience, thereby limiting their access to the containing function of the parental mind. Meltzer (1975) refers to this as ‘adhesive identity’, an affixing to, as opposed to introjection of, which “presupposes some object, however primitive, which is separate enough to be desired and taken in to the self… while in a state of fusion, no perspective, no three-dimensional view, no thought can arise”.” (p. 94). The impact is that the emergence of thinking may be compromised, making it harder for the infant to grow the psychic skin needed to develop an integrated and individuated sense of self and mind.

The resultant autistic reaction of an auto-generated ‘amour of sensuous protection’ developed in infancy (Tustin, 1992) relates to Bick’s (1968) concept of ‘second skin’ that infants who cannot, or do not, experience such containment may need to develop (for example through intense muscularity or repetitive actions) to protect themselves and their vulnerability. Containment that can be offered and taken in, over time offers a mental sense of skin can develop to then allow for thoughts about ‘me’ and ‘not me’; “there is an inside to their body which is separated from outside happenings” (Tustin, 1992: p. 40). Mental and physical holding by another and sense of a skin and ‘me-ness’, means a recovery to something more normal and a toleration of separateness.

3.4 Interrelationship between brain/mind and relational experiences

What we can understand from research and a wide range of theoretical perspectives about the developmental experiences of infants is that the brain and mind are fully situated in their relational experience. Developmental neuroscience consistently demonstrates that early relational experiences play a central role in shaping the developing brain (Gerhadt, 2004; Perry et al., 2018). Rapid change in the infant's neurological development and an "explosion of cognitive, language and social abilities" make infancy a particularly sensitive time for influence and growth (Bradshaw et al., 2014: p. 779). Gee et al. (2021) suggest that predictable, safe caregiver signals in infancy, a critical period of sensitivity, become biologically embedded and support the development of healthy emotion regulation. Conversely, when caregiving is unsafe or unpredictable, the corticolimbic circuitry (network of brain regions responsible for emotions, stress, threat and regulation) matures too quickly, reducing its window of plasticity and increasing later vulnerability, highlighting the importance of early relational support and intervention.

Neurological differences and early vulnerabilities have been identified in infants who are 'at risk' of a later autism diagnosis. Jones et al. (2017), in their study of infants with older siblings diagnosed with ASC, found that "differences in the neurocognitive systems underlying social attention may emerge prior to the infant meeting ASC diagnostic criteria" (p. 961). Similarly, Hazlett et al. (2017), offered robust evidence that early brain differences, specifically accelerated cortical growth between 6 and 12 months predicted autism diagnosis at 24 months. Whilst the studies did not address why these differences occur or how they might relate to environmental factors, the findings suggest that brain differences are likely to precede known behavioural manifestations. This demonstrates how critical this early period is for intervention, particularly given the potentially ameliorating effect of the relational environment.

Sutton (2020) links neuroscience and psychoanalytic thinking to explain how the infant's mind develops within early relationships. She emphasises that the infant's brain is highly plastic and shaped by experience, and that caregiver–infant interactions directly influence neural organisation and emerging symbolic capacities. This makes psychoanalytic concepts such as reverie and containment inextricably linked with neurodevelopment, as early relational experiences shape the neural architecture that underpins the developing mind. Therefore, disruptions in early relationships, such as through trauma, misattunement, or neurodevelopmental vulnerabilities, can affect both psychic and neural development in a time of significant neuroplasticity (Daswon, 2008).

Hobson (2002) highlights the importance of psychoanalysis in examining the awareness of someone else's mind and how this relates to the development of thought. He suggests that there is a close "connection that exists between what happens *within* an individual person's mind and what happens *between* one person and another" (p. 22) Therefore the capacity for mentalization (Fonagy et al. 2002) develops relationally and that it is this relational component that is central to the development of the mind. This is what Hobson calls the 'tools of thought', borne from the emotional engagement with others from infancy. For an infant exhibiting autistic traits, who appears emotionally disconnected, the capacity for mental life is severely compromised i.e. these "failures in personal relatedness are … fundamental to autism" (Hobson, 2002: p. 49).

Mitrani (2010) links neuroscientific and psychoanalytic understanding of autism through the study of mirror neuron systems, which help humans make sense of other's actions (p. 247). This is an intersubjective process with the parent and in turn contributes to the development of subjective awareness and empathy, where in autism there is a dysfunction in this system. Furthermore, when the parent is unable to respond adequately to the heightened needs of more sensitive infants, this lack of attunement can lead to inhibited or freezing responses. In such cases, these hypersensitive infants may reflexively shut down their mirror systems (p. 478). Singletary (2013) says that it is these neurobiological factors that interfere with the interaction between child and parent.

3.5 Research evidence-base for the impact of early intervention with potentially autistic infants

Currently, autism is assessed in the UK using the Autism Diagnostic Observation Schedule, Second Edition (ADOS-2) (Lord et al., 2012), which is a semi-structured, standardized measure for social communication, social interaction, play/imagination and restricted and/or repetitive behaviours. The earliest age that children will usually be assessed is 2 years and 4 months. In their *autism recognition, referral and diagnosis* guidelines NICE (2011: 1.4) recommend that proper training is required to recognise early indicators of autism to enable timely identification and intervention.

MacLeod and Perepa (2020) whose qualitative study looked at early years practitioners' knowledge and ability to recognise autism, identified limitations in practitioners' understanding of the early signs of autism. Therefore, highlighting the important need for this to be improved and developed if children are going to have their specific needs identified and responded to as early as possible. The complexities of the condition and being able to distinguish when it is not autism, even if it looks in some ways similar to autism, is central to this understanding.

This is in many ways an aspect of the core work of the ECMHS service involved in this study. Although not specifically assessing for autism, they are concerned with thinking about and understanding children through their emotional and interpersonal experience, whilst also considering neurodevelopmental factors. They are therefore in a key role in terms of making sense of and formulating a particular child's difficulties in ways that could helpfully contribute to autism assessment processes. The evident interplay between the developing brain and mind in its early relational context is an important position from which we understand how best to intervene and support at risk infants/ young children. There is a growing body of research relating to early relational intervention with autism, to suggest impactful outcomes for children's development.

Wan et al. (2013) carried out a study that looked at how the quality of interaction between parents and at-risk infants 12-15 months is associated with 3-year autism outcome. They identify the importance of the parent-infant relationship in either ameliorating or amplifying difficulties that may affect social functioning later, although they did not suggest that the parent causes autism. The study, carried out within the British Autism Study of Infant Siblings (BASIS), used short video-taped free-play interactions between parent and infant in a lab setting at 6-10 months and 12-15 months. 45 at-risk siblings and 47 low-risk siblings participated. Results found that parent non-directiveness and sensitivity differed between both groups at both 6 and 12 months. At 6 months infant liveliness was reduced in the at-risk group and infant attentiveness to parent and positive affect were lower at 12 months. It was the level of positive affect, attentiveness to parent and dyadic mutuality, and not atypical 'ASC-type behaviour', which predicted diagnosis at age 3. While this points to the importance of early interaction and the potential for dyadic intervention, the findings are based on short, laboratory-based observations and a specific sibling sample, which limits generalisability. The associations are also correlational, rather than necessarily proving causation and as such should be interpreted cautiously. However, the study findings identify a link between early parent-infant interaction and later diagnosis in high-risk dyads, suggesting that there is the potential to ameliorate through early parent-infant dyadic intervention that supports parental understanding and responses.

Green et al. (2013; 2017) as part of the BASIS project developed further research into early intervention for infants at risk of developing autism, drawing on previous research including Wan et al. study findings. Green at al. (2017) reported on their RCT of a parent-mediated intervention for infants at high risk of autism and the longitudinal outcomes to age three years. A relatively small study, of 54 at risk infants were randomised into a parent-mediated social communication intervention group and no-intervention (control) group. The intervention involved Video Interaction for Promoting Positive Parenting (VIPP) over 12 sessions delivered when the infant was between 9 and 14 months. They were assessed at baseline, end of treatment and then at 27- and 39-month follow-up. The results tentatively evidence the positive impact of the intervention on parent non-directiveness and synchrony, and on child attentiveness and communication initiation, with overall a reduction in the severity of symptomology (although no reduction in the rate of diagnosis).

Most recently, Whitehouse et al. (2021) carried out a randomized control trial into the efficacy of 'pre-emptive intervention on developmental outcomes among infants showing early signs of ASD'. 104 infants aged between nine and 14 months were recruited who were all exhibiting signs potentially indicating a later diagnosis of autism. They were randomized evenly so that half received an intervention and the other half received 'usual care' services provided by community clinicians. The intervention involved 10 sessions of IBASIS-Video Interaction to Promote Positive Parenting (IBASIS-VIPP). The findings showed that of those that received the IBASIS_VIPP intervention there was a reduction in severity of autistic symptoms, reduced likelihood of diagnosis at age three, and observable improvements in parental responsiveness and language outcomes. These findings are notable in a context where interventions are typically introduced post-diagnosis, although, questions remain regarding the durability of effects and applicability beyond research settings. However, these are important and relevant findings in context of the current climate of autism interventions typically taking place only after diagnosis, often with a focus on psychosocial, behavioural, pharmacological and dietary approaches to managing the condition (NICE 2013).

These studies offer a coherent and increasingly robust body of evidence highlighting the significance of early parent–infant interaction, including parental sensitivity, synchrony, and infant attentiveness, in shaping developmental trajectories associated with autism. They demonstrate how intervening in early relational processes is associated with later outcomes. This shifts the focus away from later-stage management of diagnosed autism and emphasises the role of ordinary developmental processes that are otherwise impacted by the presence of autism. This has meaningful implications for more widely evidencing clinical practice, such as that carried out by ECMHS whose focus is on early developmentally informed dyadic, relational intervention.

3.6 Psychoanalytically informed intervention

In their audited case series, Rhode and Grayson (2021) propose a convergence in psychoanalytic thinking and recent non-psychoanalytic research approaches already outlined that also stresses the importance of parent-toddler interaction in either reducing the development of more established autistic features or improving outcomes for those who go on to receive a diagnosis. They offered an observationally and psychoanalytically informed parent-toddler intervention for eight children aged between 18 and 24 months from diverse backgrounds who were all considered at risk of ASC. They all met criteria for the high-risk category of the Checklist for Autism in Toddlers (CHAT), which has an 83% likelihood of diagnosis at age three and a half. Following the intervention, a considerably lower number went on to receive a diagnosis, although it should be noted that this was a very small sample.

Rhode and Grayson say the findings warrant further investigation with a larger number of children. Their approach offered a modified version of the infant observation model from child psychoanalytic psychotherapy training as developed by Bick (1964). Rhode and Grayson suggest that the “emphasis on the observer’s sensitive receptivity” reflects research findings such as those by Wan et al. (2013) and Green et al. (2017) “on the central role of parental sensitivity and non-directiveness” (p. 3) and how parents might be supported by these qualities being modelled by the observer.

Rhode (2007) identifies that the usual process between parent and a typically developing infant is a way of interacting intuitively based on cues and patterns of non-verbal communication of increasing complexity and refinement as this reciprocal relationship and the infant develops, and which forms the basis for language acquisition. Therefore, conversely, the impact on a parent of a non-responsive infant can be devastatingly undermining and demoralising. (Raphael-Leff, 2007) articulates the potentially dire consequences for such compromised atypical communication between parent and infant:

> "When atypical communications contribute to chronic mis-attunement, the parent can no longer respond intuitively, and the baby fails to develop a smooth transition between emotional states, living in a state of hyper- or hypo-arousal with deficits in self-regulation. Defences such as extreme vigilance or dissociation are brought in as strategies to avoid unmanageable affects and ward off unpredictable intrusions. These, in turn, affect interaction" (p. xix).

Muratori and Apilcella (2022) define affective language (namely that expressed non-verbally and through the body and word language) and say that for autistic children there is not the integration of the two in the same way as for neuro-typical children. They suggest that it is the break between the affective and word language that is at the heart of autism (p. 7). They contradict the idea of autistic withdrawal and lack of interest in others, which they suggest is often a very harmful but hard-held belief about autistic behaviours. There is evidence to suggest quite the opposite is true, that individuals with autism are fundamentally motivated to socially relate with others (Jaswal and Akhtar, 2019; Muratori and Apilcella, 2022). This supports psychoanalytic thinking regarding there being meaning and communication in all behaviour, but that in autistic children these are harder to read and therefore easily missed or misinterpreted.

Aquarone (2007) highlights the benefits of very early intervention through parent–infant psychotherapy, using a psychoanalytic framework that focuses on finding meaning in behaviour, identifying very early signs, and fostering attunement and attachment to provide a foundation for meaningful relationships. She emphasises the importance of "reclaiming potential non-autistic aspects in the autistic baby at the level of developmental difficulty that will make the baby delayed if not understood in time" (p. 99). By contrast, Rhode (2007) suggests that these non-autistic parts are not absent but could be delayed as a consequence of not being attended to and therefore need to be disentangled from the autistic aspects in order to be addressed appropriately, indicating that psychoanalytically informed approaches must also be developmentally informed.

Watch, Wait and Wonder (WWW) (Johnson, et. al. 1980; Muir, 1992) is a psychoanalytically informed intervention that also draws on principles of this observational approach. The ECMHS workers who participated in this research all use this approach regularly in their work with parents and children. The intervention requires the "mother to get down on the floor with her infant; follow her infant's lead; respond to her child but only at the infant's initiative; not take over or direct the activity in any way; simple 'watch, wait and wonder'" (Muir, 1992: p321). The underlying understanding in WWW is that the complexity of some parent and infant/young child pairings are primed for influence by unresolved relational conflicts and intergenerational transmitted patterns. Muir describes WWW as 'deceptively simple' but the focus on parent's quiet, receptive and non-intrusive presence as observer to allow for the "infant's initiative in changing interactions and thus potentially changing a relational system" (p. 319).

3.7 Trauma and attachment

As more children are being diagnosed with autism, often with more subtle or complex presentations, there is an inevitable difficulty in disentangling the extent to which neurodevelopmental differences and the impact of environmental experience interlink or present in similar ways. The ADOS (Lord et al., 2012) assesses a child's presentation against a set of diagnostic features, but it offers only a limited exploration of the child's environmental context, despite attempts to address this through the developmental history aspect of the assessment. It provides something definitive, a diagnosis (or not), yet clinical experience suggests that, particularly within CAMHS, the emerging formulation for many children remains far less clear-cut, even when a diagnosis has been made. This reflects the wider clinical landscape of ECMHS, where practitioners encounter children and families whose presentations are shaped by multiple interacting factors, including psychosocial conditions and relational trauma.

As Aquarone (2007) suggests, "a history of a traumatic experience ushering autistic symptoms and developmental regressions is not unusual in case reports of autism" (p. 7). The term *trauma* can encompass a wide range of experiences, both pre- and postnatal. These may include birth-related complications such as prematurity, infection, or oxygen deprivation (Aquarone, 2007); early separation from parents; or relational trauma leading to insecure attachment (Bowlby, 1988) that may also be transgenerational (Spoladore, 2013). Increasingly, it is recognised that some children may present with behaviours that resemble autism but are rooted in attachment difficulties (Moran, 2010), or that their presentation reflects a complex interplay of both neurodevelopmental vulnerability and relational experience.

The infantile drive to connect is central to survival and to attachment development (Bowlby, 1988). Infants develop an array of strategies by which to connect with a parent but also to cope a lack of connectedness. A response might quite understandably be the infant's psychic withdrawal as a means of coping and surviving, a defensive system reminiscent of autism. Rutter et al. (1999) studied the outcomes of children from Romanian orphanages later adopted in the UK, (who are likely to fit into an attachment diagnostic criteria) presented with “quasi-autistic patterns following severe early global privation” (p. 537). This has also been referred to as ‘reactive autism’ (Aquarone, 2007). These extreme cases of trauma through abuse and neglect, cause some children ‘numb down and turn away’ as a normal evolutionary response to danger. However, instead of coming back to life when the threatening or overwhelming situation has passed, they remain in this state, because the chronic nature of their developmental trauma experiences means they do not sense that it is ever safe to come back to life (Music, 2021). Sadiq et al. (2012) studied the use of social language in children with reactive attachment disorder (RAD), which may look very similar to autism. They found that children with RAD “appear to be at least as impaired as children with ASD in certain domains of social relatedness, particularly in their pragmatic language skills” (p. 267).

McKenzie and Dallos (2017) discuss the complexities in diagnosing autism, especially when the child has several adverse environmental experiences and influences. They suggest that as a highly variable condition, where aetiology is not fully known, there can be an overlap between autism and attachment presentation. Furthermore, a link can be made between children with autism being at increased risk of developing insecure attachment patterns (McKenzie and Dallos 2017: Davidson et al. 2022) because of the impact that the autism has on the parent’s responsiveness.

Davidson et al. (2022) suggest that the autism and attachment-disorder distinction presents a “clinical dilemma”, with one understood as heritable and the other often associated with abuse or neglect. Not all attachment difficulties meet criteria for a disorder, nor are they necessarily the result of abuse or neglect, but the underlying concern remains relevant. Misdiagnosis risks pathologising a difficulty that may be better understood as dynamic and relational, rooted in psychosocial stress, relational trauma, and attachment insecurity. This can lead to a lifelong diagnostic label that obscures the potential for change offered by an accurate understanding of a child’s experiences and relationships. There will be many examples of what might be considered straightforward autism, however, the children who come into contact with CAMHS often present with far greater complexity. McKenzie and Dallos (2017) therefore advocate for a formulation-based approach that carefully considers "developmental and relational factors that contribute to symptom presentation" (p. 632) as part of any assessment. This highlights both what is needed and what is often missing in current diagnostic practices and aligns closely with the values of the ECMHS approach, which seeks to address developmental and relational dimensions.

3.8 The parent-infant dyad

This final section has an important focus on what goes on in normal development in infancy, asking the question: what is this child experiencing in terms of relatedness with another and what are the ramifications for when this is compromised? Winnicott (1960), in coining the phrase 'there is no such thing as a baby' emphasised the external reality of the mother-infant dyad and its intrinsic influence on the baby's sense of being and development. The mother provides what he refers to as the 'holding environment', in which her empathic attunement facilitates the infant's ego development from a state of 'oneness' to an individuated sense of self.

The empirical study of infant development in its early relational (dyadic) context from the second half of the 20th century onwards has seen a greater convergence between developmental psychology and psychoanalytic theory, particularly concerning the parent-infant dyad, which I will detail. Lyons-Ruth (1999) in her convergent view, suggest that internal objects and transferences are:

> "… relational control systems governed by implicit procedural models make clearer that segregated or fragmented implicit procedural maps will not only imbued with conflictual affects but are likely to be underdeveloped in various ways compared to

> procedures that have developed in relationships characterised by more coherent communication" (p. 608).

Stern (1985) shared the view that infants are active participants in their relational world from birth and that it is these early interactions with the primary parent that shape the developing sense of self. He emphasised the process of 'affect attunement', namely the process of matching in the tone, pace and contouring of cross-modal communication and behaviour between parent and infant, which profoundly affects developing attachment security and later capacities in relational intimacy. Tronick and colleagues (1978) who developed the Still Face experiment also emphasised the centrality in the mutual regulation between parent and infant, emphasising the importance of rupture and (contingent) repair in the parent-infant interaction as a key component to healthy development (Tonick, 1989; Tronick and Beeghly, 2011).

In drawing on these concepts of the co-construction of infant development, Beebe et al (1997; Beebe et al., 2010; and Beebe et al., 2012) developed a pioneering approach, using microanalysis of very early verbal and non-verbal interactions between 4 month-old infants and their primary parent (whom they identify as the mother). This was a departure from the more global assessment of parent-infant attachment development (often in the study of infants age 12 months plus) that focused on maternal sensitivity as the predictor, and instead looked at microanalysis of interactive dyadic "face to face communication and its disturbances" (2012, p. 254). With a focus on how contingent, multimodal communication (gaze, vocal rhythm and porosity etc.) as well as both self and interactive regulation (i.e. both the mother and the infant's own patterns of behaviour) form the basis of implicit relational knowing and therefore inform object representations also referred to in attachment terminology as internal working models. This approach evidenced the capacity to predict at 4 months of age, later attachment security at 12 months. Specifically, accurately identifying disorganized attachment, which they found was associated with maternal withdrawal during infant distress, inconsistent or contradictory cues (non-contingent) and confusing simultaneous responses of approach and avoid (2010; 2012).

The role of inter-subjectivity in the developing attachment relationship between parent and its impact on belonging and engagement “in the cultural learning processes of human society” is something Lyons-Ruth (2007, p. 597) explores in her longitudinal study of disorganized attachment. This extends on from the established attachment theorising on the primary function of attachment behaviours as the biological/evolutionary drive for survival through proximity seeking and comfort from a consistent and responsive parent. She suggests that the primary task of an infant is “to develop the skills for sharing affective evaluations and intentional states with others” (p. 597) as the basis for participation.

Inter-subjectivity is core to the development of mental function and is a constant, enlivened activity, central to the brains essential need to sustain itself through relatedness. Lyons-Ruth identifies the children who are faced with an ‘impossible dilemma’ of a parent who is both the source of comfort and fear. Namely, parenting characterised by either hostile/referential or helpless/withdrawn parenting and may appear to the infant both frightened or frightening, leaving the child with the need to both approach their parent for comfort and to flee from them in fear. The ‘helpless/withdrawn’ mothers are harder to identify as they may appear loving and caring and their helplessness may go unnoticed without close observation of the dynamic (Lyons-Ruth, 1999). The study found that the intersubjective patterns of relating between parent and infant, and in particular these more subtle ones such as withdrawal, was predictive of borderline, conduct and dissociative issues in adolescence.

In their recent in-depth study of atypical maternal behaviour in psychoanalytic parent-infant psychotherapy (PPIP), Miltz et al. (2023) used a single case study methodology, to provide in-depth insight into the co-creation of disrupted communication of a mother-baby dyad who fit this ‘helpless/withdrawn’ profile. The study explored the delicate work with both the mother and baby in the therapy, as equal parties with the therapist addressing the baby as an active participant much of the time. Although just the work of one case, the study provides meaningful evidence of the potential efficacy for therapeutic interventions with very disturbed mother-infant dyads. Miltz et al. suggest that PPIP is an intervention that:

> “centres on the baby’s physical and emotional states in the here and now [that] may help the parent to see the actual baby as represented in the therapist’s – as opposed to the parent’s – mind, thus contributing to a decrease of parental projections to baby and fostering parental mentalizing” (p. 187).

This study follows on from one by Avdi et. al (2020) on the same material, however their findings focus more on implicit procedural processes (non-conscious) within relational interactions and therefore also within the therapeutic relationship. The study aims to identity the multi-modal processes that occur in these interactions within sessions, such as prosody, tone, pitch, vocal rhythm and vitality, as well as more bodily responses. This understanding of ‘embodied mentalizing’ is the capacity to “conceive, comprehend, and extrapolate the infant’s mental states from his/her whole-body movement and to adjust their own kinaesthetic patterns accordingly” (p. 592).

This links with Beebe and others work on the close examination of micro-events that illuminate emerging patterns of interactions that are informing of future relating dynamics and attachment development, especially regarding implicit ‘un-thought-known’ (Lyons-Ruth 1999) or ‘implicit relational knowing’ (Stern 1998) that establishes in those very early dyadic interactions. These implicit, relational exchanges, Avdi et al, are identified also in the therapistpatient exchanges that "come to co-create a way of being with each other that produces changes in procedural 'knowing about relationships'" (p. 589).

Brandon et al. (2023) examined micro-events of rupture and repair in four different PPIP sessions using a layered analysis approach of short video-recorded clips alongside therapist reported accounts of their countertransference, finding that the two correlated. This approach enabled subtle, fleeting and unconscious events to be examined. They discovered that breakdowns in interaction could affect the therapist directly, making the therapist part of the disruption. This meant the therapist was not just observing the rupture but was actually involved in it, and the rupture became part of the overall dynamic of the therapy itself.

These communications may be indecipherable and unknown if not examined at micro level, for example a discrete physical recoil by the therapist at a moment of discord in the parent-infant interaction. The therapist's capacity for self-regulation is therefore key to containment and interactive regulation between parent-infant and in response to moments of rupture. This movement between attunement and mis-attunement and the resolution of ruptures is what Tronick and Beeghly (2011) suggests serves to deepen connection and aid development.

Lyons-Ruth (1999) proposes that relational experience is largely *implicit* and *procedural*—what she describes as "unconscious," though not in the traditional dynamic sense. She suggests that new ways of being can emerge, for example through psychoanalytic psychotherapy, within more organised and collaborative intersubjective exchanges that are themselves implicit and procedural. This perspective shifts emphasis away from an approach that may have an aim to support a development in thinking (reflective function) from procedural to symbolic coding (i.e., from preverbal to verbal forms of thought) in order to "make the unconscious conscious." Instead, as Lyons-Ruth writes:

> "…in both development and psychoanalysis, the increasing integration and articulation of new 'enactive procedures for being with' destabilises existing enactive organisations and serves as a primary engine for change. These enactive procedures become more articulated and integrated through participation in more coherent and collaborative forms of intersubjective interactions… and that the organisation of meaning is implicit in the organisation of the enacted relational dialogue and does not require reflective thought to be, in some sense, known" (p. 578).

Lyons-Ruth's emphasis on implicit relational knowing offers a way of understanding how therapeutic change can occur without necessitating verbal interpretation, providing a valuable clinical and theoretical framework for the nuanced affective work required with struggling parent–infant/young child dyads, as carried out by ECMHS.

3.9 Conclusion

This literature review has explored the relevant empirical research and theoretical literature outlining the key concepts underpinning this study. This has included consideration of the aetiology and manifestations of autism and autism-like presentations from differing theoretical perspectives, with particular attention to psychoanalytic thinking, as well as what is currently understood about intervening early when children present with autism, autism-like traits, or may be considered at risk. A central concept examined in depth, and fundamental to this research study, was the role of early relational conditions in infant and young child development. Together, these sources provide a rich theoretical and empirical foundation for the research project, highlighting both the complexity and the importance of supporting young children and their families in ways that take account of the full breadth of their experience rather than focusing solely on behavioural or symptom presentation in isolation.

Notably, no existing research was identified that specifically examines psychoanalytically informed parent–infant work carried out by professionals who are not trained in CAPP, such as the ECMHS practitioners participating in this study. This gap underscores the relevance and contribution of the present research.

4. Research design

4.1 Introduction

In this small qualitative research project, I seek to answer the research question through semi-structured interviews with ECMHS, all from the same team working with children under-5, their families and professional networks. In this chapter, I will outline the development of the research question and aims, participants, ethics, research design and reflexivity.

4.2 Research question and aims

In this study I sought to answer the research question: What do psychoanalytically informed Early Childhood Mental Health Specialists (ECMHS) in an under-5 CAMHS service offer in their parent–child work with autistic children and those under consideration for autism. What are the opportunities and barriers in their work with families and the professional network that shape how they can use their understanding of the interrelationship between brain, mind and relational experience.

I will discuss in more detail my motivations for wishing to explore this area later when I outline my reflexive stance. Here are my broad set of aims for this research study:

1. To examine how ECMHS practitioners make sense of complex presentations in young children, including those shaped by early difficulties and impingements in the parent–infant or young child relationship, how these may resemble or coexist with autistic traits, and how this understanding informs their clinical approach to intervention.

2. To explore how ECMHS practitioners bring their psychoanalytic, relational, and developmental understanding into their work with families and multidisciplinary networks, and to identify the opportunities and barriers that shape their ability to apply and communicate their perspective, particularly on the interrelationship between brain, mind and relational experience.

3. To investigate how an early relational perspective is maintained or constrained once an autism diagnosis has been suggested or made, including the extent to which curiosity about the child's social and emotional environment is preserved or reduced, considering the drives for diagnosis seeking and potential resistance to applying/including a relational and developmental lens, and within wider cultural, social and political contexts.

4. To consider what the work of ECMHS, who are trained in psychoanalytic infant observation but are not CAPP-qualified, reveals about the potential for a broader workforce to deliver important, psychoanalytically informed early intervention within CAMHS.

5. To strengthen understanding, practice, and future research by examining how children with complex backgrounds are assessed and supported when autism is being considered, raising awareness of their clinical and service needs, and identifying priorities for further investigation.

4.3 Participant recruitment and interviews

Recruitment of participants was relatively straightforward in the sense that I identified a team I wished to interview members of the ECMHS team. The essential inclusion criteria were that participants had completed a pre-clinical infant observation training (or equivalent) and had worked within the past year with a child whose presentation was relevant to the research question. The team is relatively diverse in terms of age, race, and professional experience, although all members are female. The team consists of two ECMHS practitioners who are qualified CAPPs and five ECMHS practitioners with a range of professional backgrounds, including health visiting, paediatric nursing, and psychodynamic psychotherapy. In discussion with my supervisor, I made a conscious decision to exclude the two CAPP-qualified practitioners. This was to strengthen the validity of the study by focusing on those with broadly similar training backgrounds and to explore how a wider workforce, beyond formally trained CAPPs, can meaningfully contribute to this specialist area of work.

Having completed study in infant observation, they approach their role with the understanding that the relational, social, and emotional context surrounding the infants and young children they work with is central to recognising their needs and shaping the interventions they provide. They work across the city and therefore with a highly diverse demographic. Although the team represents the only under-5 CAMHS service in this locality, limiting the breadth of possible sampling, I believe there is sufficient diversity of perspectives within the group to generate rich and meaningful data.

I initially approached the team lead to seek her permission to disseminate to her team information about my research project for them to decide if this was something they wished to take part in. I then sent out a recruitment email (Appendix A), after which I was invited to a team meeting where I was able to talk through my project idea and aims. I gathered initial interest from this meeting and followed up by sending out Public Facing Documents (PFDs) including an information sheet (Appendix B) and consent form (Appendix C) and received signed consent from all five team members I had approached.

4.3.1 Interviews

I arranged to meet with each potential participant at a clinic location and time most convenient to them. I also asked ahead of the interview that they come prepared with some relevant case examples. I explained at the outset that I would record the interview and transcribe it as soon as possible post interview, after which I would delete the recording. I also explained the steps I would take to protect their anonymity, including the use of pseudonyms, the removal of identifying details, and ensuring that any interview extracts used in the write-up could not be traced back to individual participants.

I developed an interview schedule (Appendix D) that aimed to explore with participants their understanding of autism, the relevant children and families as well as professional networks that they encounter, how they work, what works well and what are the challenges. It was important to ensure that all were asked the same questions. However, semi-structured interviews allowed meto probe beyond the initial answers and therefore enter a dialogue. This meant that the participants could expand on their answers to offer greater depth to response, whilst remaining in a structure that allows for comparability May (2001).

For each participant to feel comfortable and safe enough to talk openly and therefore provide rich and authentic data (McLeod 2015), I needed to ensure that they were clear about what I was hoping to think about with them. I provided an information sheet ahead of the scheduled interview time as part of the consent to take part process. I then set about helping them feel at ease by opening each interview up by asking them to tell me about themselves and their professional backgrounds and then reminding them of the research question. I was also able to provide a curious and open atmosphere by drawing on skills that I have as a therapist to be an open and empathic listener, picking up on any non-verbal cues and asking helpful probing questions where necessary (McLeod 2015).

4.4 Ethics

4.4.1 Ethical approval

I applied for ethical approval via the Tavistock Research Ethics Committee (TREC), which was approved in December 2022 (Appendix E). Due to the study not including anyone considered vulnerable, I did not require any enhanced ethical considerations.

4.4.2 Informed participation

It is imperative ethically that potential participants are comprehensively informed of all elements of what they are being asked to take part in, how their data will be gathered and used so that informed consent is given. As previously stated, I ensured that they received information about the study ahead of the interview via verbal contact and the use of PFDs and they understood their right to withdraw consent for their data to be used up to three weeks after the interview took place.

During the interview, I explained the process and how their data would be treated in terms of confidentiality and storage, as well as steps to ensure their anonymity in the final write-up, as previously outlined. I also addressed the potential of a difficult emotional response evoked in the participant by the process of talking about these issues by making them aware that if needed, we could take breaks or stop the interview all together, although these measures were not required.

Following the interviews I sent out a de-brief letter (Appendix F) that thanked them for taking part and outlining who they could contact if they had further questions or concerns and signposting to support services should they be left with difficult feelings from the discussions within the interview. None took this offer up and there were no reported issues or concerns following these interviews.

4.4.3 Confidentiality and data storage

To ensure confidentiality for any child, family or professional discussed during the interviews I requested that participants were aware when discussing to be as broad as possible in their descriptions and that they did not use names. When it came to writing up, I did not use extracts that referred to the specificities of examples given that may divulge identities. However, the examples they did give helped to illustrate vividly the different aspects of experience being discussed.

Following the interviews I transcribed as soon as was practically possible, anonymising information and then storing the documents in a password protected computer file, which are securely stored for a period of five years before being destroyed. The only other person to read any of the anonymised transcripts was my supervisor.

4.5 Design

4.5.1 Analytic method for data

I chose reflexive thematic analysis (RTA) because it offers flexibility as a method rather than a fixed methodology. This allows for the integration of broad theoretical frameworks and researcher subjectivity is acknowledged and considered an asset that enriches the analytic process (Braun and Clarke, 2022; Campbell et al., 2021). This makes it particularly well suited to the psychoanalytic frame within which the study is rooted. RTA also aligned with the aims of this research, as its adaptable structure supports the use of semi-structured interviews to explore the nuanced and complex nature of work with children, families, and professional networks. While flexible, it still maintains rigour, and its openness to interpretation requires the researcher to be active, engaged, and thoughtful in their approach (Braun and Clarke, 2022, p. 9). It sits comfortably within a Big Q qualitative paradigm, which focuses on generating knowledge that is contextualised and situated.

In answering the research question, I aimed to explore the intricacies of the experience and what this may illuminate about the needs of these children and their families. The assumption behind this approach was that the data reflected a version of reality as described. At the same time, I recognised that this reality is shaped by personal and systemic factors and therefore cannot be considered the only truth. The reflexive nature of RTA acknowledges that meaning is co-constructed, shaped by my own personal, professional, theoretical, cultural, and political background. This fits with the psychoanalytic framework I have drawn on as a trainee and now qualified CAPP, where unconscious processes at both individual and group levels are understood to influence experience and relational dynamics. From my prior experience as a child protection social worker, I was also alive to the complexity of oppression and disadvantage that affect these more vulnerable families, so experience can never exist outside of its social, political and cultural context. I kept these ideas in mind throughout the analysis.

Although I brought professional experience and ideas about the conditions surrounding this work, I approached the data inductively. I immersed myself in the dataset, engaging with it systematically and iteratively to extrapolate meaning in a creative way. My intention was not to prove a hypothesis but to discover something about the lived experience of the work of these ECMHS and how this is contextualised systemically. For this reason, the themes that emerged across the dataset as a whole were more important than a case-by-case focus on individual interviews.

I focused on identifying semantic themes that captured explicit meaning in the data while remaining attuned to latent, implicit content in the responses. RTA allows for movement between consideration of semantic and latent meaning. I was mindful of how participants might filter what they shared, recognising the presence of unconscious defences against anxiety (Holloway and Jefferson, 2013). These defences may have been shaped by how they perceived me as the interviewer, perhaps as an expert, and by the sensitivity of the subject matter itself. Anxiety about not knowing or saying the wrong thing was palpable. The theme exploring who is right (the expert) emerged as central to the data and was closely tied to the issues the research aimed to explore. This was particularly interesting to observe and reflect on throughout the process.

RTA felt more appropriate for this research than other methods such as Interpretative Phenomenological Analysis (IPA), which centres on the personal meaning-making of each participant and is less concerned with broader thematic patterns (Smith et al., 2009). Grounded Theory (GT), while valuable in other contexts, would have been too prescriptive and rigid for the aims of this project. Transparency in how the data was collected and analysed is essential to ensuring the credibility and validity of this qualitative research (McLeod, 2015).

4.5.2 Data analysis

I closely followed the analytic process set out by Braun and Clarke (2022), as follows:

1. Dataset familiarisation – I began by transcribing the audio-recorded interviews verbatim without using any software, which offered a useful first close contact with the minutia of the data and began the process of data analysis. I then read each transcript once to have a sense of the whole interview and then again but this time making detailed notes about general ideas and concepts. I began considering how individual transcripts sat within the dataset as a whole, and how ideas might link. This was an immersive process that allowed me to really familiarise myself with the material.
2. Data coding – I then went through the data and identified sections/points of interests that may develop meaning across the dataset and 'applied analytically-meaningful' descriptions (data codes). These codes identified ideas and concepts made up of single words, phrases or longer explanations. As I carried this out with each transcript in turn (in date order) I was thinking tentatively about how codes may group together and interlink within the whole data.
3. Initial themes generation – Initially this involved pulling together clusters of codes that suggested certain ideas and concepts that might contribute meaningfully to answering my research question. This was a process of constructing themes, based on the data, rather than extracting themes already there. From this, I identified potential themes and then assigned relevant coded data to each potential theme (Appendix G).
4. Theme development and review – Having taken time away from this, I returned to my potential themes, reviewed how they fit with the analysis of overall dataset and thought

further about what meaning could be made that is relevant to my research question (does it tell a ‘convincing’ story) and existing research identified in my literature review.

5. Themes refining, defining and naming – This is the point at which I ‘fine-tuned’ my analysis to ensure that I have evidenced it well in my assignment of data codes to themes, ensuring that the themes were evidenced by codes widely from the dataset, rather than too heavily from one or two transcripts. I played around with how themes could be combined or split, refined and then how they interwove to tell the story of the dataset. I developed key ideas to summarise the points of each theme to help me feel clear on what it is I wanted to say about the findings from this data analysis. I then worked and re-worked the theme names to ensure they were ‘concise, punchy and informative’. I identified the final intersecting themes as *Negotiating expertise in the understanding of autism, A place for thinking and what shuts it down, Barriers to holding the child’s multifaceted experience in mind, Intervening with a psychoanalytic lens*
6. Writing up – The part of the process that brought together the analytic narrative by assigning data extracts that ‘vividly and coherently’ illustrated the different aspects that made up the themes to pull together a thoughtful, nuanced and in-depth story of the dataset. As with the coding and theme development, the editing of this final write-up was a multistage, iterative and reflexive process that I had to keep leaving and coming back to in order to produce the final Findings report.

The findings are an examination of these professionals’ experience at a point in time. Whilst I think it likely that the themes that arose from this data set are relevant to other contexts, the research is not intended to be generalizable. However, my aim was to address the research question, offer some in-depth insight into this area of work, contribute to thinking and highlight potential areas of need for further research.

4.6 Reflexivity

It is important that I talk about the influences that brought me to this research question. My thinking was initiated by a young child I saw for psychotherapy over a long period of time. At the beginning of treatment, they had just received a diagnosis of autism, despite knowledge of their exposure to maternal toxic stress in utero and postnatal depression as well as other stresses in the postnatal environment. Over the course of the psychotherapy, including the positive parent work and obtaining an Education Health Care Plan (EHCP) and consequent identification of appropriate school placement, their presentation significantly shifted. This suggested that their complex presentation could also be understood as a response to their environment, which therefore changed when this became more supportive, suggesting more than just a fixed neuro-divergent profile. This presented many questions to me about what was influencing that making of diagnosis and what does it mean that this child has a lifelong diagnosis that at worse could be wrong but at the least does not tell the whole story.

I had attended a multi-professionals meeting to discuss the EHCP that was focused on behaviours and symptoms, and I found it hard to contribute my psychoanalytic voice that I felt was not welcome. I wanted, therefore, to find out how those trying to work psychoanalytically managed to and what this highlighted about the current climate of understanding and working with these children, their families and professional networks.

I come from a background of Child Protection social work, prior to taking up the CAPP training, so this inevitably has a bearing on a systemic lens through which I can make sense of things, especially in terms of advocacy and social justice for disadvantaged children and families. Through my psychoanalytic training, including personal analysis, I have developed an ever-deepening understanding of and capacity to observe closely and to think about the complex interplay of external and internal worlds of children and their families, but also how the professional network and organisational group dynamics are played out. It was striking to me how complex and profoundly important these processes of assigning potentially lifelong diagnoses are to these children with complex backgrounds. From my position that a psychoanalytic framework for understanding these children is both useful and essential, I wanted to understand more about ECMHS experiences of trying to offer this. Furthermore, given what a critical time under-5 is in a child's development, I thought it most useful to explore this professional group's experience, rather than those working with children across the age ranges.

As I engaged with the research over time, I became increasingly aware of how my thinking, understanding and reflections were shifting and deepening. I noticed the influence of my own values, particularly my sense of justice for these children and their families, and how this shaped the questions I asked and the meanings I was drawn to. My initial curiosity gradually developed into a more sustained effort to make sense of the complexities involved, not only in how individuals and professional groups think about these issues, in both aligned and opposing ways, but also in what these patterns of thought reveal about wider societal dynamics.

This process led me to reflect more critically on the systemic and cultural forces that shape how children's difficulties are understood, including the ways in which certain forms of suffering become individualised rather than recognised within their relational or social contexts. What began as an interest in exploring professional perspectives evolved into a stronger moral commitment to understanding these dynamics to contribute something of value to children who are at risk of being overlooked within current structures.

Braun and Clarke (2022) are clear that “reflexivity involves a disciplined practice of critically interrogating what we do, how and why we do it, and the impacts and influences of this on our research” (p. 4). Whilst understanding that objectivity was not achievable or indeed an aim for this research project, it was important to keep my subjectivity under scrutiny to ensure that it did not unduly influence the findings of my research. I therefore regularly took my thoughts and workings to supervision and my research seminar group, which offered a very helpful ‘third position’ to my thinking. I have chosen to write in the first person deliberately to acknowledge my reflexive stance as the researcher. Writing in the third person would suggest more distance from the data analysis and research piece than I am aiming for within my methodological approach.

5. Findings

In keeping with the inductive underpinnings of RTA, themes were developed through an open and iterative engagement with the data. I began by immersing myself in the material, first through transcription and then by repeatedly reading each transcript. After coding each transcript, I searched for broader patterns of shared meaning across the dataset, identifying 32 items that were organised into initial themes (Appendix G) Through an iterative process of cross-checking codes and experimenting with different ways of combining or separating themes, I refined, defined, and named the final set.

This process led to the identification of four major themes: *Negotiating expertise in the understanding of autism, A place for thinking and what shuts it down, Barriers to holding the child's multifaceted experience in mind, Intervening with a psychoanalytic lens*; with 13 subthemes (see Results table 1). Consistent with an RTA approach, my aim is to "tell [the] whole analytic story" (Braun & Clarke, 2022: p. 118) by weaving the data into a narrative that addresses the research question. The order in which themes and codes are presentation is intentional, and the content of the finding does overlap and interlink. Extracts have been selected to best capture the essence of each point, with attention to a balanced representation of voices across the participant group.

Table 1:

Themes	Subthemes	
Negotiating expertise in the understanding of autism		*What is autism and who is the expert?*

		Challenges of contributing a relational perspective
A place for thinking and what shuts it down		*Opening up space for thinking*
		Defences against thinking
Barriers to holding the child’s multifaceted experience in mind		*Parent difficulties*
		Class
		Ethnicity and culture
		Lack of resources
		Systems
Intervening with a psychoanalytic lens		*Observation*
		Unconscious communication and therapeutic alliance
		Containment

5.1 Negotiating Expertise in the Understanding of Autism

5.1.1 What is autism and who is the expert?

An important aspect of working with autistic children, and those under consideration for autism, is developing a clear understanding of what autism is. Yet the question *“What is autism?”* quickly revealed itself to be far more complex than it first appears. ECMHS unique contribution to the understanding of these children’s experiences, in the context of more diagnosis orientated systems, is one of the central concerns of this research. The participants’ responses also illuminated the question of who is positioned as an “expert” and why?

Across the interviews, participants struggled to offer a clear or definitive answer to the question. This difficulty did not reflect a lack of knowledge, but rather the challenge of articulating a universal diagnostic definition (NICE, 2011) or the criteria embedded in "gold standard" assessment tools such as the ADOS (2012) in a way that captures the complexity they encounter in practice. Their accounts pointed to a more nuanced and less concrete understanding, one shaped by their psychoanalytic and developmental perspectives, and by their work with children whose developmental pathways are often complicated by early adversity and complex unconscious relational dynamics.

Participants frequently hesitated or expressed ambivalence when attempting to describe autism in diagnostic terms. Their sense-making was grounded in this appreciation of the complexity of early development when there are impingements in the environment, making it difficult to separate "autistic traits" from the impact of trauma, parental mental health, or early relational disruptions, especially with the children they encounter, and as such they appeared hesitant to be too definitive.

At the same time, this hesitancy seemed to expose a lack of confidence in their knowledge, and whilst they were familiar with the key features outlined in diagnostic frameworks, several participants found it challenging to speak with any clarity in that language:

> *I would probably describe autism as a scale of emotional difficulties ... more like social and emotional difficulties that can occur at an early age ... I am trying to put it into words that sound correct.*

Their difficulty in articulating autism diagnostically highlights the tension between the clarity promised by checklists and the "grey areas" encountered in real clinical work. Participants appeared to "breathe life" into diagnostic categories through close observation, attunement, and an intuitive grasp of relational dynamics. Their working knowledge of autism was clearly sophisticated. Rather than relying solely on diagnostic criteria, they described a more experiential, relationally informed way of recognising autistic presentations:

> *You are taken into their world and little comes back ... that to-and-fro-ness just doesn't happen ... sometimes it can be a bit cut off and frustrating and sad.*

Yet they also conveyed a sense that this richer understanding is not always easy to convey to give it legitimacy so that it is recognised or valued within multi-professional contexts. One participant, describing a child with a complex infancy, whose mother had been severely depressed, received a diagnosis from Paediatricians, noted:

> *There was little scope for some of that psychoanalytic language to come into these reports.*

The participants gave the impression that whilst they hold a nuanced, relationally informed expertise, the systems around them may privilege more concrete, medicalised accounts of autism. Also, there appeared to be a distinct lack of confidence on the part of the participants to hold their important and valid perspective on the relational and developmental experiences of these children, to contribute to the thinking and formulating with professional authority.

5.1.2 Challenges of contributing a relational perspective

The tension between the drive toward diagnosis and their own commitment to understanding the child within their relational and environmental context was threaded through all the interviews. Participants described the often polarising positions between how they and some parents and professionals may differ in how they conceptualise autism, whether as a fixed, inherent condition requiring diagnosis, or as something that can also be understood through the lens of relationships, development, and experience, as well as neurodevelopmental:

> *Whether it is seen as something that is quite fixed ... and almost there is nothing that can be done about it ... Whereas maybe there could be other ways of thinking about it.*

For ECMHS practitioners, the relationship itself remains central:

> *In our role, it is so about working with the parent and the child and working with their relationship ... whether or not there is a diagnosis of autism, there's still a relationship to work with.*

Although participants described positive collaborations with some professionals, they also spoke of a persistent conflict between diagnostic imperatives and relational thinking. Several described feeling "up against" colleagues whose approaches were more categorical or medically driven, or systems that lacked the time and resources to support reflective practice. This sometimes left them feeling deflated or marginalised:

> *If there are professionals ... who are much more clear-cut in their mind-set, I can find it quite hard to constantly go up against that ... I kind of give up ... there is that sense of what is the point.*

Participants described paediatricians as often occupying a position of authority, with diagnostic checklists treated as the "gold standard." One participant reflected on a multi-professional meeting where ECMHS are given a token opportunity to contribute:

> *You get five minutes ... it's very brief ... it is predominantly quite a medical way of thinking.*

This dynamic appeared to shape how families positioned ECMHS practitioners, sometimes valuing their input only once a paediatrician had endorsed the possibility of autism. One participant described being initially dismissed by a family because she was perceived as someone who "didn't think it was autism," and reflected on the absence of relational considerations in the final autism report illustrating how diagnostic frameworks can overshadow relational formulations, even when relational factors are central to the child's lived experience.

5.2 A place for thinking and what shuts it down

5.2.1 Opening up space for thinking

A central feature of ECMHS work is the offer of space for *thinking* in depth with families and professionals about the child and their relationships. Thinking being a process of *being with* as much as cognitive linking and sense-making. This largely home-visiting model, offering a variety of long and short-term work, depending on need, allows stories to unfold gradually, enabling a richer and more contextualised understanding of the child within their relational context as well as the therapeutic relationship with ECMHS. This, participants reported, felt particularly important when considering children for whom a diagnosis was being sought to explain a more complex problem to allow space for thinking to become more possible and develop.

All participants agreed that most children seen by ECMHS cannot be "neatly" diagnosed as autistic and the complexity requires time, which in autism assessment services is not afforded, as they are often time-limited to one or two sessions in a clinic (alongside completion of questionnaires and developmental history), before providing a report and diagnosis (or not). ECMHS approach to holding a "wait and see" stance, one that tolerates uncertainty, presented a challenge when considered within systems that often seek diagnostic clarity. As one participant reflected:

> *It's very clear to paediatricians that it is autism and it's less clear to me whether it is autism or the experiences they have had ... there is so much more early childhood trauma that is undiagnosed versus the amount of autism that is diagnosed.*

One participant described the difficulty of encouraging curiosity once autism has been named:

> *Once autism starts being named ... it sort of cements ... it's there and it's difficult then to think.*

The participants offered vivid examples of the complex interplay between early experiences, relationships, and developmental vulnerabilities. Their language reflected psychoanalytic, developmental, and trauma-informed frameworks, which shaped how they formulated and intervened. This was evidently a unique and different approach to understanding the children they encountered in which autism or potential autism is a feature. An approached contrasted with formal autism assessment processes, which do not completely negate the wider environmental factors, but equally are potentially restricted to a more limited appreciation of their interplay.

5.2.2 Defences against thinking

Participants described their expertise as rooted in close, detailed attention to the relational and social context of the child, what one called a "microscopic" level of observation. Yet they frequently encountered resistance to thinking relationally, both from parents and professionals. When autism is suggested, there can be a pull toward locating the problem within the child rather than exploring the relational environment. In this way, diagnostic processes are used as a defence against thinking.

Several participants linked this to parental fear:

> *Sometimes it can be fear of the unknown ... wanting to find a cause ... because if you can make sense of it with a diagnosis, then it's almost like thinking, "this isn't actually me".*

Others highlighted how professionals may also defend against relational thinking:

> *There is so much intellectualisation ... the actual reality and the heart and the being human with the child is forgotten.*

Participants noted that the period of waiting for a diagnosis can further inhibit relational thinking:

> *While they are waiting ... parents often find it difficult to think more relationally and perhaps need more structure and strategies.*

Some parents, they felt, became fixed on diagnosis to the exclusion of other work:

> *The ones that are fixed on the diagnosis ... refuse all other bits of work except going to the paediatrician.*

In cases where trauma or relational disruption is significant, a diagnosis can obscure these factors:

> *If an autism diagnosis has been given without recognition of early childhood trauma ... the relationship bit will never be thought about.*

Yet participants also recognised that seeking a diagnosis can be motivated by a desire for support:

> *It's wanting their child to succeed in life.*

This nuance is important: the pursuit of diagnosis is not inherently defensive but can become problematic when it shuts down thinking about the child's relational world.

One participant captured the painful consequence of unacknowledged trauma:

> *That's not to do with autism, that's to do with the traumas that people around the child have had, which they are bearing.*

Another described how relational patterns can become self-reinforcing:

> *It gets so entrenched you can't turn it around.*

Participants noted the normalising use of autism terminology such as "masking" or "stimming", to justify a diagnostic framing even when alternative explanations may be possible. This presented yet another way in which thinking about the behaviour could be shut down, when in fact it might be understood in far greater depth to know something of the child's individual experience and modes of being. Even when a behaviour is correctly identified as "autistic," there remains something important to be understood about what that behaviour means for this child.

What participants seemed to be describing is a powerful drive, in the face of many competing challenges and experiences that are hard to make sense of, toward clarity and certainty, which appears to soothe by giving definition. This desire for certainty at an individual level is reinforced by systems that provide the conditions to defend against the painful experiences of uncertainty, the unknown, and the complexity of experience rooted in relationships. It is of course understandable that parents want and should have neurodevelopmental concerns assessed and identified, but it seems that what the ECMHS are encountering is a significant resistance to holding two things in mind at once: both the neurodevelopmental and the environmental context. The many barriers to this will be explored in the next section.

Participants described the emotional intensity of holding a thinking stance in the face of reductive or premature diagnostic framing. One reflected on how easily she could be pushed into a polarised position, highlighting the potential risk from the ECMHS to become overly invested in proving that it is *not* autism:

> *I almost end up justifying their A behaviour as not autistic … and I don't know if I should do that.*

The work was often described by participants as emotionally labour-intensive, particularly when practitioners felt they were advocating for the child's fuller experience:

> *It's so hard to visit families who want something that you don't think is useful for the child ... it feels very damning for the child.*

When thinking could be contained within a smaller, more aligned professional network, participants described greater success in supporting parents to shift toward a relational perspective:

> *There weren't too many other voices ... so there was room to really work in a psychodynamic way.*

However, wider networks with conflicting perspectives could dilute or undermine this work.

Across all interviews, participants conveyed a strong sense of seeking justice for the child, wanting them to be seen as a whole person rather than reduced to a diagnostic label:

> *You give the child a name ... they are their own little person ... it's not "because he has autism he won't be able to do that".*

The participants responses captured both the emotional commitment and the ethical stance underpinning ECMHS practice: a determination to keep the child's lived experience at the centre of thinking, even when systems and narratives pull in other directions.

5.4 Barriers to holding the child's multifaceted experience in mind

There were consistent areas that all participants identified as barriers to parents and at times professional networks being able to engage with the relational work ECMHS offer, particularly when thinking about their child's behaviour and presentation in a broader sense rather than solely through an autistic lens. These barriers apply across much of their work, but they appeared to be intensified in the context of possible autism, where the prospect of a more "straightforward" answer than to have to consider more complex interplay of experience. The problem is located solely within the child, reducing the need to consider the wider relational and environmental context.

At an individual level barriers related to parental insecurity and defences that were often developed in the context of their difficult childhood and life experiences, often of trauma (developmental, childhood and transgenerational) and consequent impaired functioning, (such as through the impact of poor mental health, substance misuse and domestic violence). Often in the context of socio-economic difficulties in relation to poverty, class, poor education, inadequate housing, a lack of support network, and the impact of race and culture including English as a second language. All of which is compounded by a current climate of limited public resources including for basic living needs, universal services such as Health Visitors and other early intervention under-5's services such as Children's Centre provision and specialist services for which there are long waiting lists, as is the case with the autism assessment service and CAMHS itself.

5.4.1 Parent difficulties

All participants talked about the anxiety, shame or fear that many of these parents felt at the prospect that they have caused their child harm or that this is what people are going to judge or criticise them for. For some of these parents to consider that their child's difficulties may arise from both innate sensitivities and relational experiences is a significant emotional task, especially if they have had best intentions to protect their child from the disturbances in their histories. For those already carrying feelings from the impact of trauma, this can feel especially overwhelming and hard to bear as it ultimately is asking them to take a position of responsibility, which might feel more like blame. As such, the participants consistently reported that this served as a significant barrier being able to think about their child relationally and what might be affecting them and their difficult presentation, as described here:

> *It's too hard for them, it's too upsetting ... challenging to consider that they have any part in the dynamics or the child's behaviour.*

… and here:

> *I wonder if it is something quite difficult to think about how they might have contributed, so whether it is guilt or shame or fear of having done something wrong. That's what can be very difficult, and I wonder if that is what is a barrier to them thinking about their relationship with their child and that is quite hard to work with ...*

This participant eloquently described how it can be too painful to attempt (or even have the capacity at all) to imagine the experience of their child, that they [the parent] are not equipped with the mental apparatus due to their own deep levels of pain:

> *I think the challenges are where the parents ... how much can they bear their own child's struggle and if they are not mentally in a place where they are able to hold the struggle for their child, it's more difficult to be able to be really able to work with the relationship ... because there's a sense that they need to defend against their own pain. Therefore, it's easier, especially with professionals coming in and saying it could be autism, to hook on to that.*

It seemed that the idea of autism could become a useful way for a traumatised parent to escape the complexity of making sense of why their child is struggling, just as their own struggles have not been attended to. One described a mother who could not see beyond their child's behaviour and her sense of feeling persecuted and needing someone else (the professional) to stop it, rather than knowing that it was within her power to help change things for the child and herself:

> *…she didn't want to focus on the relationship she just wanted to stop the behaviour and in fact she said to me "I don't see why I should change".*

This participant framed it in terms of the parent's brain being so hijacked by their own traumatic memories that the space is not there to think about anything else:

> *What is most challenging is working [with] parents that suffer with severe trauma. Because whilst still getting PTSD flashbacks and so forth, it is really hard sometimes to have that thinking space for the child, dealing with the other voices in your head. I don't mean in terms of you know, in terms of hearing voices, but trauma being played back.*

This participant described an example of how one parent's own legacy had become the lens through which they perceive their baby's feelings towards them, all entangled with their deep anxiety about rejection and not being enough:

> *… she was about 6 or 7 months old when she was referred and the mum was just adamant that it was autism … and it wasn't, you could tell it wasn't. The baby was developing so normally, so typically. But for the mum it was her way of understanding her own feelings of rejection and the slightest signal of baby not wanting to connect … it was too painful I guess to think of anything else, so it was like, I'll put it down to autism.*

The painful experience of parenting when one's own childhood experiences of being parented are marked by such complexity is already a challenge, but to then parent a child who may require more sensitively attuned caregiving is a considerable undertaking. The participants showed a nuanced and compassionate understanding of this, even as it created challenges for their work in building a fuller understanding of the children. It can also be understood as a central feature of their unique role, work that goes beyond simply identifying problems and instead involves a dynamic process of relational meaning-making and the consequent impact on functioning this has as understanding develops.

5.4.2 Class

Class as a theme was threaded throughout the case examples given by all the participants. The examples of traumatised parents appeared inextricably linked with socio-economic disadvantage, although this was not always explicitly stated. Alongside the confronting feeling of looking at their relationship with their child due to their own distress and difficulties, was the sense that socio-economic disadvantage could and does have an impact on how easily and readily parents can access this way of thinking.

This participant described this challenge:

> *I suppose lots of things [are a barrier], poverty – a big factor. Other relationships, extended family, whether that is absent grandparents or abusive partners or the things that mean it is difficult to find that safety to think about these things. Money, housing, you know all comes into it, in terms of being able to come to a space and think about their child, not feel threatened or challenged by that.*

Here a participant talked about the challenge of working with parents whose histories have impacted their capacity to trust professionals and the importance of recognising and working with this:

> *A huge barrier is parents' experience of professionals generally. Especially lower socio-economic picture of families, maybe they have had social care involvement or they have had very poor experience of people believing them or trust issues. So it becomes very hard to let them feel safe, and I think that's a huge part of the role, enabling people to feel safe in order to share their struggles to then be able to connect them up with.*

This participant, in talking about the experiences of adopters, suggested that the stability or instability of a parent's background has a central bearing on how well they can engage with this kind of work:

> *Well their background, class, education. The adoptive parents were professional, more middle class and secure stable childhoods and just got it, you know could just get it. It's not always the way, some adoptive parents have been through a lot of struggle, they feel 'I am letting this child down, I am not good enough for them, this child needs more than me' and they bring their own little demons with them.*

Another seemed more energised when talking about a middle-class, professional parenting couple who were fully signed up to work with her post-birth. The sense was that these parents could be helped because they were better able to engage with the concepts and the language:

> *Well today, I met a woman who is having a caesarean tomorrow. Many rounds of IVF and some miscarriages. They are [high status professionals], they have hopes for this baby, obviously. They've been through all the stuff they've been through and we're going to do a new-born behaviour observation, as soon as mum feels ready after the birth.*

In the example given here, there was a more implicit indication of the impact of class differences between parent and ECMHS which seemed to relate to value judgments, which seemed to contribute to the challenge in engaging the parent:

> *It feels very distrustful to question the parents' behaviours and motivations. It puts me again in a dilemma, because you know once again I want to believe what parents have to say, but there are some very disturbed parents and sometimes we come across them.*

> *And the children are disorganised around the parents' scheme for them. So it's horrible, horrible.*

Whilst not explicitly identified by any of the participants, I did wonder about the impact of difference between ECMHS and parent; how this influenced the capacity of some parents for connection and engagement in the work and relationship with the ECMHS. What all the participants seemed to experience is the need to build a connection and trust by parents that they will not be criticised and judged, to feel more able to tackle confronting and difficult conversations about their children and the relational dynamics that might be playing out in the child's behaviour. For some this is not possible without the validation of the diagnosis, when it may feel more possible to think about the relational aspects of their child's experience once there is a sense the 'problem' has been more formally rooted in the autism. The participants seemed to be talking about how feelings evoked by difference and perhaps a sense of the superiority of the ECMHS (through their more complicated psychological ideas and concepts), is too greater a barrier for some parents to overcome, especially given their experiences of often-intersecting points of disadvantage.

5.4.3 Ethnicity and culture

All participants talked about the challenges specific to working with families from different ethnicities and cultures, particularly communities of immigrants for whom English is their second language or not spoken at all and who are somewhat on the outside of the general British population. This participant suggests that these families are less likely to be referred in the first place because the families do not frame the need as a 'mental health' one:

> *Yesterday I was meeting with some children's workers and a Somali worker asked how we work with families from other cultures where they might have a different sense of what emotional wellbeing is, or mental health is. I suppose that is a challenge and*

> *whether it is that we have fewer referrals from people from other cultures, because ... the family not seeing what the difficulties are in the way that we might offer to work with them.*

However, the implication here too is that they are not being referred by other professionals and it is interesting to think about why this is. What might it tell us about assumptions possibly being made about the willingness and capacity to engage in this work by parents from these communities?

One who was working with these communities identified the differences in perception about what the difficulty is and how it is a consistent barrier to offering support to these families:

> *…you know people may see the child as sick if they have got behavioural problems, something presenting like autism. They may want the doctor, the paediatrician to make a diagnosis, rather than thinking in a relational way about it, or [about] the emotional world of the child.*

Another challenge relates to the use of translators:

> *…that's one of things that can be difficult when you are trying to do this relationship work when English isn't the first language and you're relying on translators to translate what you are saying accurately to the parents and what you are saying can get lost in translation.*

One participant talked about the very slow and painstaking work she did with one parent through a translator to try and make sense of why she was struggling so much with her son (who was thought to be autistic), which was raising safeguarding concerns. The real story of what was going on related to the influence of cultural practices the mother was subjected to as a child in the country where she grew-up, and understanding this shed a whole new light on what was going on and informed the best way to work effectively with this family:

> *... but actually understanding her story was great, because it just opened my eyes to thinking, ok, you need to think differently with this family ... you need to think about in terms of what a parent's journeys is, what her needs are and empathise a bit more with her ... what do we need to put in place for you so you get a bit more understanding about what's going on for your children.*

Whilst these barriers to engagement with these communities are applicable to many other scenarios, and not just when there is suspected autism, it does raise interesting and important point about how certain presentations and behaviours, that in a western culture are clearly defined diagnostically, but may be conceptualised in a very different ways in another culture. To really understand requires a sensitive, curious and diligent approach as described by these participants and that this groundwork is essential if these children are to then successful access autism assessment services.

5.4.4 Lack of resources

Of concern to all was the overarching impact of the current social and political climate, namely a significant stretch on ever more limited resources. They described a lack of considered, systematic and consistently complementary joined-up working, despite its potential to make a big difference to processes and outcomes for these families. They recognised the impact of poverty, inequality and trauma as huge and complex social problems. The sense they gave was that these things are not only hard for individual parents - and at times professionals - to think about but are too hard for society to think about and require a lot of resources to tackle. Pathologising and labelling children may feel more manageable to many, as this participant articulated:

> *I think there is so much more early childhood trauma that is out there that is undiagnosed versus the amount of autism that is diagnosed. When you are looking at childhood trauma, then you have to pull in the whole dynamic, which is harder for parents, harder for society ... because there are so many components that you actually have to do more to do something about it.*

All participants talked about the extremely time-sensitive need for the babies and young children they work with, which was not currently supported by the long waiting lists and lack of early intervention and support:

> *... because it's a year, 18 months, who knows, [waiting for autism assessment] it's not fair to leave them. It's stopping them getting other services that could help them. You know babies can't wait for that stuff.*

This highlighted further negative impacts to those parents from socio-economic disadvantage who already faced complex challenges in accessing services. This participant talked of the disparity in accessibility to support depending on your socio-economic status:

> *I guess it depends how much people are invested in the NHS, a lot of the time the ones that can afford it will go private and I think those ones can generally get support because they can afford to pay out for specialist sort of support. What they are missing are those children of parents who are not in that fortunate position to afford that, unless they can provide that through the NHS they slip under the radar.*

All participants talked about the parents who were determined to access a diagnosis and feel their only option is to aggressively advocate for their child. This participant suggested the reasons why professionals get on board with parents who are pushing a certain agenda, despite the evidence of other environmental challenges:

> *Some parents can be quite pushy and quite difficult if they feel you are withholding a diagnosis, can feel quite fragile and can cause a lot of possible complaints and things like that. When I talk to parents sometimes, they're motivation is to get what the child needs in terms of either funding or resources.*

All described vividly the challenges of navigating this terrain of scant resource, and the tussle for parents to get what they feel they/their child needs. Therefore, the sense was that these parents struggle to invest in ECMHS work (even that if it does alleviate some of the challenges) partly through fear that this could gather evidence that their child is not autistic or could risk them being pushed down the priority list, or off the pathway altogether. This reluctance is therefore understandable given the disparity in access to resources for children with a diagnosis, for example through an Education Health Care Plan, compared to those who are 'simply' struggling due to contextual issues.

5.4.5 Systems

Despite their descriptions of the great deal of good work being done by different professions, it was suggested that there were not the systems in place to work in a meaningfully collaborative way. The work carried out by ECMHS could offer valuable insight into the autism assessments of more complex children, but it seemed rare that they formally contributed and there was no specific pathway. Here, one described her involvement by chance:

> *I went with the Speech and Language Therapist and observed one of her sessions and so then she obviously knew that I was involved so that led the way. It seemed to happen a bit ad hoc, rather than an official part of the process. I happened to be at the right place at the right time.*

This showed the impact of this lack of joined-up thinking:

> *Because everything is segregated professionally, and I don't think COVID helped with that, so that sense of coming together to have those discussions has been lost. I think sometimes for us ECMHS working with the under 5's those complex case discussions don't happen quite in the same way, so I think that might bring some of that richness to that thinking around the presentation. As with autism, even if clearly autism, there is always more going on, the relationship is there to think about.*

It was suggested that there was a need to link in and think together more effectively with other professionals so that their perspective can be more useful:

> *I think that we are distant from the professional network, there isn't assessment. I don't think we link very well with the paediatricians, we don't see them face to face. We don't link very well with the autistic hub. I do think there is a lot that we can offer, but we need more staff and it takes more time than people think to gather the whole picture, especially the ones we help.*

This implication was of a lack of system that brought minds together thoughtfully and offering time to really explore the possibility of autism or not and perhaps come back to it later, when it was not a clear diagnosis. Instead, they described a window of opportunity to diagnose, leading to a potential for forcing through the assessment outcome without proper consideration.

5.5. Intervening with a psychoanalytic lens

Central to the ECMHS approach, as they described it, is the relationship; both the close examination of the parent–child relationship and the quality of their own relationship with parents and young children, the subtlety of their 'being with'. Their accounts of what 'being with' involved, whilst seeming deceptively simple, involved complex processes in which their sensitive, sustained observation, reverie and careful attention to transferential dynamics, provided containment, allowing difficult experience and uncertainty to be taken in, held, and thought about. This approach applies across their work more broadly but demands particular skill and attentiveness when encountering the defences and barriers to thinking that they suggested are often present when there is concern about autism. It offers further insight into the challenges and needs that arise when thinking about potentially neuro-sensitive infants and young children, and which these participants are actively attending to in their work: namely, the difficulty and necessity of hyper-attunement to an infant or young child whose modes of relating may be harder to read and understand. The subtleties and intricacies of relating therefore form the substance of the distinctive intervention these participants offer.

Frameworks and approaches that draw on psychoanalytic and attachment theory-informed interventions, including, Watch, Wait, Wonder, Video Interactive Guidance (VIG) and Circle of Security are used by all. However, the nuances with which their work required careful thought, flexibility and the capacity to bare the difficult feelings that arouse, including parents' hostility and anxiety. They described carrying out some very successful, sensitive and skilled interventions with parents and important and meaningful contributions to professional networks, despite the challenges already outlined.

5.5.1 Observation

At the heart of their application psychoanalytic thinking, is drawn from knowledge and skills developed on the infant observation course, which all completed prior to taking on the role. All gave very powerful case examples in which observation was used to illuminate something relational for the parent, with powerful effects, as this participant described in her work:

> *... we did some Watch, Wait and Wonder ... did some beautiful work and after a while he was able to just touch her, communicate by just holding her face, used a few more signs and so forth, and the screaming started to go down.*

The sense was given that a more observational, thoughtful approach allowed for a space to capture something that could then be thought about:

> *I think the Watch, Wait, Wonder is another good one. I think [it] captures the togetherness, the moments of connection and the parents' ability to think 'what is going on with me, with us, with our little one' ... step away from 'is it or isn't it autism', but we have a little person here regardless and let's just think about that.*

What these examples show is not only the importance of supporting close, benign observation to build understanding, but also the connection and shifts in relating that this can bring about. It supports the 'being with' that gradually builds contact through a greater capacity for thinking and 'taking in', rather than 'pushing out' into a fixed set of traits in the child. The participant felt that approaches using observation, such as Watch, Wait, Wonder and VIG, offered a platform for thinking about the feelings evoked in parents and the thoughts they have about what they observe in the here and now, as well as space to begin making links with wider experience and history. The 'wondering' in the work is an invitation to move away from seeking definitions and certainty and instead being open to the different forces at play and the meaning behind behaviour.

For some parents, the 'in the moment' experience of using observation seemed to feel safer than focusing on history and general functioning and so allowed space to look at something that otherwise might have felt too difficult, and which highlights the sensitive judgement required by these ECMHS to know how much can be tolerated so that some meaningful relational work can still be achieved, as this participant describes:

> *VIG or WWW is more in the moment, the here and now of the interaction, it feels a bit more of a safer way to do that relationship work. For some parents making those connections [to the past] just isn't helpful, it's not what they need.*

The containing and thoughtful presence of the ECMHS seemed to provide the conditions in which parents could observe and be with their children with attentiveness and curiosity, to powerful effect, such as the example given here by a participant, of an autistic child who also due to adverse early experiences had completely shut down causing parents to despair, who through the course of the intervention developed the capacity for relating and communication that had previously felt completely absent:

> *…. we were learning to be at one with him. This little boy started communicating, some words started to come out and you know, really appropriate words too. He didn't have a full language but they [he and parent] had a real understanding, he was showing that he was beginning to understand and be understood.*

5.5.2 Unconscious communication and therapeutic alliance

Whilst not explicitly applied as a psychoanalytic therapeutic method, such as relating to the use of transference and countertransference, all the participants talked about the tool of understanding the unconscious communication from parents and children encompassed in what they do and say, as well as their own emotional experiences and responses to it. They demonstrated an understanding of the transferential nature of some of their interactions, especially with parents with troubled backgrounds whose internal landscape may consist of persecuting and hostile forces, and therefore whose trust in them and their work challenged. This participant's description illuminates something of this and the feelings the parent may not be able to bare for themselves, such as humiliation and fear, that they then wish to project, rather than think about:

> *Sometimes just trying to push the 'what life's been like for you, what life's been like for little one' and trying to link that is too difficult and that can come across as a parent being guarded and angry and cross and frustrated … they do give that ridicule, that*

> *'why are you bothering talking about that'? For some parents, going too much into that is too sensitive or too raw or just not helpful in that moment in time.*

The participants talked about the fundamental need to establish and build on the therapeutic alliance quickly, meaning that the negative transference is noted rather than 'worked with', as it might be by a CAPP. There is a recognition that many of these parents will need support to see the ECMHS as something potentially useful and not hostile or defensively dismissed as pointless, meaning careful consideration and sensitivity is needed, especially early on in terms of parent's expectations and defences. As this participant outlines:

> *I think the preliminary work in setting up your stall, as it were, for the work is so important. Right from the word go when that referral comes in, having that personal conversation and saying 'hi, this is what we are able to offer' and then having that initial appointment at home if it feels comfortable for them, so really being alongside and containing their anxiety about whatever.*

The participants talked aften about the time needed to build trust and a solid therapeutic alliance over time, and how fruitful this could be, as described here:

> *... because of the length of time we have been working together, she feels safer and more able to think, to link little bits about what is happening in those early days with him, link some of it back to when she was younger. So to be able to think about what is going on in their relationship feels a bit more possible for her.*

The intervention is through the relationship with the ECMHS, so that the relationship between parent and child can be thought about. This is an important distinction in work with autistic or possibly autistic children, as it shifts the focus away from labelling the traits and challenging behaviour the child presents with, and brings it back into its relational realm.

A fundamental part of this unique approach is how the participants countertransference serves as a guide to their understanding and work with these children and families; the *felt* experience of being with these children (and parents). When thinking about how it feels to be with the children for whom autism is being suggested these said:

> *…often sadness, something lacking, something kind of lacking in terms of connection between the child and parent ... sort of missing each other, which is often something that is very difficult to witness.*

Also:

> *I think a lot of things sometimes do come down to what does it feel like to be with this child and whether they are autistic or not? Do I feel like an object they are just stepping over? I went to little girl where mother had extreme anxiety ... and this little girl did walk over me and bump in to me as if I wasn't there or as if I was a thing ... no eye contact, lots of twirling in front of the television, watching the television at this sort of close quarters. No interaction with the mother. It was bleak.*

…and:

> *I think internally I get quite anxious and maybe it is parent's anxiety being put in to me.*

…and:

> *Repetitive. I am just thinking about two children, and you know you are taken into their world and little sort of come back, that too and fro-ness just doesn't happen. Sometimes it can be a bit sort of cut off and frustrating and sad.*

Whilst these would not be considered reliable measures for diagnosis, they offer a deeper attuning to and understanding of these children's internal landscapes and their struggles in relating. The ability to gain insight into the emotional lives of these children is an important aspect of the work, especially when autism is in question, as it allows for space to think about the child, their emotional life and what they are communicating, rather than simply seeing them as displaying an array of perplexing symptoms or behaviours. They can then be attended to with understanding and thoughtful relational input, as supported by ECMHS interventions.

5.5.3 Where containment can lead

The essence of the work of ECMHS when successful, was the experience of containment they offered to parents that created space in the minds to really think about and take in their child. Many of the parents they encounter have experienced breakdowns, sometime catastrophic, in containment, either in their early experiences or now in their parenting. The ECMHS is offering a container-contained function, and it is through this that change and development can happen:

> *It's those [parents] who stay and we continue doing a piece of work together that are the ones that are able to hold some level of this [thinking] as helpful ... 'help me think about the relationship with my child and how I can enjoy that more, and how I can help her [my child] enjoy that time with me'.*

The same is reiterated here, framed within Circle of Security language, 'hands on':

> *A lot of work may be around containing [parents] anxieties, providing a space where they might be able to start to think. You're almost like the hands that will be supporting them, and they can then support their children:*

This participant described the experience for a parent who, after various interventions and a lot of input from ECMHS, was able to move away from anxieties about harming her child to being able to mother him:

> *... there is still a lot going on with both their health needs, but it feels like she is able to think about him and to think about what she can offer him as a mum.*

This participant talked about how making the concepts accessible is a way of containing parents, rather than alienating them as discussed earlier in this chapter. This was supported by the Circle of Security approach:

> *The Circle of Security training is very much attachment based and it's highly researched, using psychotherapeutic theories, so it has that basis, but it has been really well set up to bring a simplicity about being based in relationships, but given in very simple terms.*

The role of containment that these participants described as essential to the role, often meant taking in disturbance and holding a space for thinking, when it otherwise wanted to be avoided, could be emotionally challenging and laborious. They all talked about the need themselves to be contained due to the emotional demands of the role, which they described receiving through supervision and as a team. One described this sequence of container-contained, container-contained as:

> *…like hands on, hands on, hands on.*

Another described the important function of supervision as a space to think:

> *… in cases where I think I'll need support in terms of what we are going to do next with this family, because it's kind of weighing you down … and having space to think with somebody else, sometimes that's really helpful to be able to do that.*

They all talked about the challenges of working with more disturbed parents and where there may be concerns of abuse or neglect; how essential the right supervision was to support comprehensive thinking and aid compassionate work with the parent (especially when it feels hard to feel compassion):

> *I guess you've got to think, well this child and this mum are going to be paired together and trying to come alongside and validate the mum a bit more is probably something I have tried to work on quite a lot. I think having a psychotherapist as a supervisor is crucial to do that, you know in the work that we do.*

Finally, in thinking about what is important, they all agreed that early intervention and more joined-up working were needed, as well as building the skill set and confidence of universal health-care providers, such as Health Visitors, to broaden the scope of what could be offered to these families in a timely way. More robust early intervention was required for parents from the outset, to address the impact of their own histories and help mitigate the extent of difficulties that might later emerge in their relationships with their children. Containment at a systemic level was therefore lacking; participants felt that thinking and services could join up more effectively to piece together the whole experience for children, rather than leaving them with fragmented experiences, something they felt had not yet been achieved, despite the good work happening in different parts of the system, including their own.

6. Discussion

I will now consider the themes that emerged from the Findings – *Negotiating expertise in the understanding of autism, A place for thinking and what shuts it down, Barriers to holding the child's multifaceted experience in mind, Intervening with a psychoanalytic lens* – in more detail. I will make some links with the empirical research and literature outlined in the Literature Review, alongside other relevant research and literature. In discussing and making conclusions about these findings, I explore how my following research aims were addressed:

1. To examine how ECMHS practitioners make sense of complex presentations in young children, including those shaped by early difficulties and impingements in the parent–infant or young child relationship, how these may resemble or coexist with autistic traits, and how this understanding informs their clinical approach to intervention.

2. To explore how ECMHS practitioners bring their psychoanalytic, relational, and developmental understanding into their work with families and multidisciplinary networks, and to identify the opportunities and barriers that shape their ability to apply and communicate their perspective, particularly on the interrelationship between brain, mind and relational experience.

3. To investigate how an early relational perspective is maintained or constrained once an autism diagnosis has been suggested or made, including the extent to which curiosity about the child's social and emotional environment is preserved or reduced, considering the drives for diagnosis seeking and potential resistance to applying/including a relational and developmental lens, and within wider cultural, social and political contexts.

4. To consider what the work of ECMHS, who are trained in psychoanalytic infant observation but are not CAPP-qualified, reveals about the potential for a broader workforce to deliver important, psychoanalytically informed early intervention within CAMHS.

5. To strengthen understanding, practice, and future research by examining how children with complex backgrounds are assessed and supported when autism is being considered, raising awareness of their clinical and service needs, and identifying priorities for further investigation.

6.1 Negotiating expertise in the understanding of autism

Autism is now universally understood as a neurodevelopmental condition defined as a set of traits, behaviours and challenges in social communication, that can manifest in a varied ways and on a spectrum of severity (NICE, 2011; APA, 2013). The interactions between genetics and environment, including prenatal and postnatal experience are broadly accepted as contributing factors in aetiology (Satterstrom at al., 2020; Modabbernia et al. 2017). Whilst there are comprehensive links between genetics, neuroscience, developmental psychology, epidemiology, and early social intervention made in research (Lord et al., 2020), it has only been in recent years that organicist research has started to identify that intervening in the early relationship between parent and infant, in particular supporting parent sensitivity and reciprocity, can have an impact on the way in which symptoms of autism develop and are mitigated, to differing degrees (Wan et al., 2013; Green et al., 2013; 2017; Whitehouse et al., 2021).

These important findings from research offer empirical evidence that converges with long held ideas in psychoanalytic theoretical thinking (Tustin, 1992; 2008; Alvarez, 1992; 2016; Rhode, 2007; Meltzer, 1975). Psychoanalytic perspectives understand that broadly speaking there is a psychic experience for autistic children in infancy, in which unbearable and unmanageable feelings of separation lead to protective and defensive responses that impact on normal processes of separating and individuating. Therefore, essential to what all these psychoanalytic authors are saying is that the complex processes of togetherness and separation form part of the relational reality on which development depends, specifically the relational context between parents and the infant or child. Whilst a biological perspective offers important information about the why and how of autism's aetiology and manifestation, these psychoanalytic concepts go further, offering an account of the nuanced, fundamental relational experiences that are central to how development unfolds and in shaping the developing individual mind of the infant. These theoretical ideas highlight the importance of understanding how early relational processes may unfold differently for autistic infants, and how caregivers and clinicians might support the developmental process of these infants, even when early processes of reverie and containment falter.

This grounds the parent-child relationally focused work of ECMHS in empirical evidence and supports their meaningful contribution to autism formulating within professional networks and with families. However, these participants described the challenge of finding a confident and credible voice that can contribute meaningfully. They gave a sense of larger, more dominant systems that are reluctant to engage with the nuanced influence of relationships and intersubjective experience in any meaningful way. They described at times a fragmented professional approach to assessing and supporting children who present as autistic, which is often viewed either through a relational lens or a behavioural and individualist one. The latter can appear more legitimate and desirable, partly because of its perceived authority, which perhaps stems more from its clarity and structure within a medicalised framework than its appropriateness to the subtle ambiguities of the task in hand.

The first question 'what is autism', was difficult for all participants to answer with the kind of clarity typically found in a well-defined diagnostic criteria checklist such as the ADOS (Lord et al., 2012). This seemed to contribute to a lack of confidence in their expertise when it came to autism presentations. Yet each participant's procedural and working knowledge was clearly well developed, especially in their understanding of subtle presentations and in their capacity for detailed observation and a felt sense of being with these children. This struggle, and at times reluctance, with definition also said something about the grey area in which these ECMHS sit.

What their insight offer is a sensitive understanding of the impact of autistic ways of being on the relationship between parent and child, which could be what has the most significant long-term impact on the child's development and wellbeing. Contemporary psychoanalytic thinking views autism as an organic condition while also recognising "autistic modes of functioning" (Klauber and Rhode 2004: 264) that can shape how an autistic child develops and relates. Alvarez (1992; 2016) highlights how neurological vulnerabilities can limit an infant's ability to make use of early care, while their atypical ways of relating may in turn affect parental responses, creating defensive patterns and increasing disconnection. What Tustin (2008) termed psychogenic autism (psychic damage rather than neurological), could be better understood as the way in which organic vulnerabilities are expressed within the relational environment, what Alvarez calls the "power of an effect to become a cause" (1992: p. 187), shaping the child's emotional life and patterns of relating.

Therefore, the need goes beyond simply identifying autism, but that this must be understood within the relational environment and intervene accordingly. Otherwise, there is a risk in focusing too narrowly on behaviour as a set of diagnosable features, especially when filtered through the now normalised colloquial shorthand of autism terminology. These participants spoke about how terms like "stimming" are often used in a reductive way, bypassing any curiosity about what the behaviour might mean.

The pull towards reductive terms and the allure of the checklist and concreteness of diagnosis, appears to meet a wider need for something clear and definable. There is a common drive in people to seek out a definitive understanding through diagnosis by a trusted authority, such as a doctor, rather than engage with a more difficult, often painful aspects of emotional, social and relational experience.

The language used within different perspectives plays a crucial role and may even be a defining feature in the contrast between diagnostic and relational approaches. The medical model tends to rely on clear, assertive, and checklist-driven language, which gives it a sense of legitimacy and authority. In comparison, the language of relationships and emotional states can feel less defined and be dismissed as vague or ‘fluffy’. Yet this softer language often holds the complexity and depth of lived experience. This way of speaking may be alienating in its intimacy, especially to the parents often described by these participants, who are defended against getting too close to the feelings of the experience of their child and themselves. Therefore, it may be easier to scoff at and dismiss the language as having less authority and legitimacy. For example, one participant described the ridiculing response she can receive from some parents when she tries to talk to them in these relational terms.

The participants framed their relational, infant and young child mental health expertise as being on a microscopic level, looking at the particularisms of the relationship, rather than the generalisation of behavioural strategy that occupies the wider medicalising perspective. They are looking at the child in a relational and social context. There is an inherent tension between a particularising and a generalising view. One does not need to take the place of the other, but there are certain consequences about one dominating approach. A paediatrician may not actually think that the ‘problems’ are all located within the child due to their having autism, but the reality is that a diagnosis will often have this effect. This could be particularly the case with parents and professional networks who are defended against thinking outside of this framing.

6.2 A place for thinking and what shuts it down

A central concept emerging from this research is the fundamental interrelationship between the brain, mind and relational experience. Developmental neuroscience consistently demonstrates that early relational experiences play a central role in shaping the developing brain (Bradshaw et al., 2014; Gee et al., 2021; Gerhadt, 2004; Perry et al., 2018). We understand that early experiences, including neurodevelopmental vulnerabilities have an impact on psychological and neural development in a time of significant neuroplasticity (Daswon, 2008). Neurological differences and early vulnerabilities have been identified in infants who are 'at risk' of a later autism diagnosis (Jones et al., 2017). These findings from neuroscience research link with psychoanalytic thinking to explain how the infant's mind develops within early relationships Sutton (2020). Hobson (2002) argues that the development of the *tools for thought* are rooted in the infant's emotional engagement with others, suggesting a close link between internal mental processes and interpersonal experience, and provides the relational basis of mentalization (Fonagy et al., 2002). Early disruptions in relatedness and therefore emotional connections undermine the development of mental life, making such relational failures "fundamental to autism" (Hobson, 2002: 49).

Processes of r*everie* and *containment* (Bion, 1962a) - the ability of the parent to receive, and metabolise the infants raw, unprocessed emotional states (Beta elements) so that they can help transform them into more digested, thinkable form (Alpha function) - are how the capacity to think and know about oneself and others is borne. This is the basis of what Bion (1962b) refers to as the K link, namely the drive for knowledge about oneself and others and the ability to turn raw experience into meaningful knowledge. This approach to knowing is a central function of the work of ECMHS with parents and infants where containment has often failed to transpire. These are parents who find taking in their infant's experiences and thinking about them, painful and difficult. Regardless of the presence of autism, there are often other factors in these families' lives, including intergenerational adversity, which means that these failures in containment run deep and form barriers to thinking that I discuss in more detail in the next section. The pull towards diagnosis can act as a defence against the anxiety of what thinking might stir up; namely, what Bion refers to as – K, which is the drive to mis-know or avoid painful truth, perhaps through fear of its catastrophic consequences. Therefore, diagnosis soothes by offering clarity, but often at the cost of deeper understanding. The participants all described their need to hold a position of thinking about the unthinkable, often in the face of real resistance that is in many ways reinforced by a societal, political and cultural context that is also defended against thinking. As one participant eloquently reflected, it is easier for society to attend to individual problems, such as through diagnosis, than societal issues such as childhood relational trauma.

Whilst not discussed in the literature review, McGilchrist's (2009) insights into how the two hemispheres of the brain offer fundamentally different ways of engaging with the world, feels relevant to the findings in terms of the wider social and cultural phenomenon of diagnosis seeking. The right hemisphere is concerned with context, relationships, and lived experience, and the left with abstraction, categorisation, and control. Both are essential and should work together, however, McGilchrist argues that modern Western culture has tipped too far into the left hemisphere's way of knowing. Codification and reductionism have taken a lead, often at the expense of depth, empathy, and connection. As a result, we view the world as it is abstracted, rather than as it is lived, losing any sense of nuance or relational depth to our understanding of what is actually going on. This imbalance is evident in our bid to understand and make sense of mental health and conditions such as autism, solely through diagnosis seeking. Diagnosis can start out as helpful by defining and clarifying but easily create distance from the actual experience by reducing complexity and over generalising, which suggests an absence of *negative capability* (Bion, 1970), namely the capacity to not know, and to sit with uncertainty that can so often feel unbearable at both individual and societal levels.

Again, whilst not discussed in the literature review, Pilgrim's discussion of existential vulnerability and ontological insecurity is relevant here. He describes how a need for excessive ontological security "may result in rigidity, uncritical thinking, and even prejudice. A degree of insecurity might be necessary as it opens space to explore difference, both within us and in others" (2010: p. 41). Pilgrim reflects on the difference between mature and immature relating, and the societal tendency to seek elite leadership that promises simple answers to complex problems. Despite growing awareness of intergenerational trauma within wider cultural narrative and within policy (see ACEs Study, Felitti et al., 1998) there appears to be a strong pull, both individually and systemically, to keep things simple, rather than tolerate difference, stay with the unknown or uncomfortable and complex reality of individual and relational experience.

This is epitomised in our current systems and culture around diagnosis. We are living in a time where diagnosis is popularised and shared widely on social media, which seems to have contributed to a noticeable rise in diagnosis seeking to make sense of distress and difficulty. It therefore has the effect of reinforcing the hierarchical notion that the doctor or medical system knows best, and that trust should be given without scrutiny. That is not to say all diagnosis is reductive, but often it bypasses curiosity about the complexity of experience and presentation.

6.3 Barriers to holding the child's multifaceted experiences in mind

The parent-child experience is inextricably linked to its wider environmental context, including the role of trauma and attachment. Aquarone (2007) suggests that traumatic experiences, ranging from birth complications to early separation or relational trauma, are frequently reported before the emergence of autistic symptoms, with attachment and relational trauma difficulties at times resembling autistic traits (Bowlby, 1988; Moran, 2010). Neurodevelopmental vulnerability and adverse relational experience, oftentimes intergenerational shape and complicate autism presentations (Spoladore, 2013). Furthermore, children with autism are at increased risk of developing insecure attachment patterns (McKenzie and Dallos 2017: Davidson et al. 2022) because of the impact that the autism has on the parent's responsiveness. These findings paint a painful and difficult picture of complicated processes of cause and effect, and effect becoming cause (Alvarez, 1992).

The relational approach by ECMHS means that something about how these difficulties in children were borne from the relational experience with their parents (and their parents before them) poses an obvious challenge for many of these parents to think about, given their own histories. For a parent to arrive at a service that focuses on thinking together about the emotional life and experience of the parent-child relationship, rather than offering a definitive answer to the problem assumed to sit within the child, may feel confronting, difficult and despairing even. It is this therapeutic rather than diagnostic approach that offers a shared and relational process of discovery, but it asks of parents a willingness and ability to engage with a closeness to the experiences of themselves and their child and with the ECMHS, as well as the implied need to take some responsibly for their child's difficulties, which may feel too painfully like blame. Therefore, this requires some capacity to sit with the discomfort of guilt, uncertainty and bear the frustration and anxiety that may arise.

For many parents who have experienced a catastrophic failure of containment in their own infancy, thinking outside of diagnosis and more relationally requires a lot of them. A challenge to any parent who also may have tried hard to protect their child from their own childhood disturbances. Without the validation of a diagnosis, that recognises there is the presence of something neurodevelopmental, the desire or capacity to think about the brain, mind and relational correlation might be too hard to think about, as these participants described was often the case. It also may be important that the neurodevelopmental aspect is diagnosed to help create the conditions for thinking. Particularly so, as there is conversely the risk of professionals such as ECMHS being pulled into an equally rigid position of only wanting to view things relationally, as one participant described.

When ECMHS work was successful, it could be transformative, but time was needed to build trust and allow this thinking to unfold and develop, no small feat. The tentative and gradual approach of the ECMHS work therefore stands in contrast to autism assessment processes, which typically involve questionnaires and limited face-to-face sessions. That partly reflects the structure of the autism assessment framework but also speaks to the current climate of stretched services, where demand is high and waiting lists are long. There is pressure to complete assessments quickly and efficiently. There is not the time to think in a more wait and see way, as the ECMHS approach advocates, and nor are systems in place for professionals to think together meaningfully so that uncertainties can really be reflected on.

In this context, some parents may feel even more strongly about pursuing the diagnostic pathway and avoiding what they see as being side-tracked by having to think about the relationship, especially if the reality is that there is only one chance for referral and assessment. But also, for many, where dependency and intimacy are ultimately unsettling or even disturbing experiences, the formality of consultation and diagnosis may feel preferable as it offers distance, particularly in terms of locating the ‘problem’ within the child and not in relation to the parent, may feel more bearable than making intimate contact with the relational experiences of themselves and their child, that ECMHS work offers.

The impact of race, culture, class and socio-economic disadvantage, and how these intersect, are also important and relevant factors that shape the experience of these dyads, particularly in how they access and make use of this kind of service. Issues of difference are complex and were evident in the experiences described by these participants, especially in how successful they were in engaging parents to work with the relationship. Whilst not spoken about in-depth by all the participants, there was an implicit theme around difference and how the perceived and actual differences between ECMHS and parent (especially in terms of class) may impact on the work.

Disadvantage is often associated with the impact of parents' own early and often traumatic lives, the socio-economic context they live in, and the associated lack of education. These seemed at times to act as alienating forces when trying to support them to trust in and engage with this way of working. It was notable that the parents who could engage more easily, as described by some participants, were those who had the education and language to access the concepts. Additionally, parents from significantly different cultural backgrounds, and where English is a second language, required very sensitive and meticulous work by the ECMHS to break through barriers to reach mutual understanding and begin addressing the parent-child relationship.

6.4 Intervening with a psychoanalytic lens

The work of ECMHS involves working with complex unconscious communication, including primitive anxiety, disturbance and defences in both parent and child, which must be observed, borne and then metabolised to create a space for thinking and change. This is true of all their work with parents, infant and children. However, this becomes potentially even more pertinent when considering infants and young children where there is a diagnosis or suspected autism, whose atypical communications lead to mis-attunement and hinder parents intuitive responding

(Raphael-Leff, 2007). Early intervention using a using a psychoanalytic framework, seeks to support parents to find meaning in the infant or child's behaviour, so that attunement can be supported to improve the relational environment essential to development, that could otherwise be disrupted (Aquarone, 2007). This means supporting parents to better understand their child's bids for connection and that relational drive is present, even though atypically expressed and harder to read (Jaswal and Akhtar, 2019; Muratori and Apilcella, 2022). The need for a more hyper-attuned parenting response is not easy, especially given the multitude of barriers that many of these parents' face.

This work of ECMHS in attempting to address these support needs in their intervention, is often done quietly over time, whilst navigating various environmental and psychic barriers. ECMHS must build a strong and containing relational frame to allow for this delicate and often fraught work, and where safety and trust must be established first. They all described the emotional labour of the work, often requiring them to sit with the uncertainty and complexity of emotional and relational experience that accompanies these parent-child relationships. This is more so when they are trying to hold a space of curiosity and not knowing (Bion, 1970), when certainty and clarity are being sought in the form of diagnosis. Their capacity to think needs nurturing through their own containing experience of supervision; a process of container-contained-container-contained.

Central to their work is the importance of understanding normal infant development, which is inherently intersubjective (Beebe et al., 1997; 2010; and 2012; Stern, 1985; Tonick, 1989; Tronick and Beeghly, 2011). This understanding can get lost once a diagnosis of autism is made, when difficulties are often assumed to arise solely from neurodevelopmental factors and curiosity about the child's social and emotional environment diminish. This suggests a broader and often implicit assumption that the social and emotional difficulties associated with autism are not responsive to therapeutic (relationally focused) intervention. Although as already detailed, research tells us otherwise (Wan et al., 2013; Green et al., 2013; 2017; Whitehouse et al., 2021).

The ECMHS described the nature of their work as *being with* relationally. It is part of the process of *thinking about* that is the unique offering of their work in developing a more in-depth understanding. This reflects the quality of presence between parent and infant, in a more embodied, non-verbal sense such as through tone, gesture, rhythm and contingent emotional response and resonance (Beebe et al., 1997; 2010; and 2012) and that close, benign observation is key (Johnson, et. al. 1980; Muir, 1992). The links between the "implicit, unconscious procedural processes in human interaction" (Avdi et al., 2020: p. 589) and the foundational aspects of early intersubjective experience in establishing both a sense of self and relational knowing is also what is replicated within the therapeutic relationship between the ECMHS and parent and child.

These implicit rational exchanges are as central to the work as is the verbal exchange in creating meaning and bringing about change (Avdi et al., 2020), including micro moments of rupture and repair (Brandon et al., 2023). The participants conveyed that the nature of the work often required them to tune into internal experiences, which were not always easy or indeed necessary to articulate. Instead, what they offered was processes of reverie and containment, in their capacity to take in and think about them (both child and parent), including the hard to bear aspects that others are defending against having to think about. Therefore, the conveying of experience often remained at an implicit level by their attentive, curious and thoughtful presence and the relational space that this created. This is particularly relevant when the "being with" and "thinking about" between parent and child is difficult or painful for the parent. Much of ECMHS's work involves navigating this sensitive and finely balanced space between what is known, what can be tolerated to be known, and what must first be experienced, such as a felt sense of safety between ECMHS and parent, and their careful, close observational stance and reverie.

The ECMHS supports the parent-child in co-creating being together and finding a voice for the 'un-thought-known' (Lyons-Ruth 1999) or 'implicit relational knowing' (Stern 1998). This puts into context the participants' struggle to find the language to describe a phenomenon that is seemingly straightforward when understood within the definitions of a checklist, but in their experience harder to capture verbally. They are working with very primitive states that are not necessarily accessible through language alone, they are preverbal, procedural, felt in the body, manifesting in phantasy and acted out defensively. These complex interaction of unconscious experience and processes can be at odds with current cultural lexicon relating to diagnosis and neurodevelopment to make sense of more complex experience.

Much of this work require ECMHS to bear what cannot be easily borne by parents, at times other professionals and the systems within which they sit. It takes huge confidence on their part to *not say* what could be said, for parents who want some sort of articulated framing, or indeed society that has a need for neat definitions and to not have to think too deeply about the experience of these infants and their parents. Therefore, the power of the work of ECMHS is that it does not spell everything out, like a diagnosis may do in a discrete written up assessment. Instead, the parent (and child) is offered an opportunity to discover for themselves a different understanding that comes from a relational 'being with' rather than an explanation of abstracted components; an unfolding and relational shifting that reflects early process in the development of the mind, thinking and relational knowing.

7. Conclusion

7.1 Summary

A psychoanalytic approach begins with the belief that a child’s behaviour carries meaning. Supporting parents to develop their capacity to observe closely and find meaning in their child’s behaviour, fosters greater receptivity to the child’s communication and relational bids, which in turn supports healthy development, for which there is a growing body of empirical research to evidence. This input can be especially important, when hypersensitive attunement is required due to neurodevelopmental vulnerabilities. However, there are several barriers that parents and ECMHS encounter when trying to establish this approach, often linked to parents’ complex histories and disadvantaged contexts, but also in the systems, including cultural and societal, that can also defend against thinking in this relationally linking way.

The study highlights the problems that arise from an overemphasis on behaviour in isolation as a set of diagnosable features, which shuts down thinking and risks overlooking the unconscious meaning and communication behind behaviour, which is often embedded in a complex relational context. There is a clear need for the different frameworks to understand, assess and intervene with children with an autism presentation and the work of ECMHS offers a unique and valuable insight, despite their struggle to confidently take their place at the multiprofessional ‘table’. Importantly, they attend to the complexity and multifaceted nature of these children’s presentations and maintain curiosity about their social and emotional development within their relational context, which can often be overlooked once autism is a consideration or diagnosed.

This study emphasises the interrelationship between brain, mind and relational context. Especially in early childhood development and supports the ameliorating effect of working with the early parent-child relationship when autism is a presenting issue or concern. The findings suggest that therapeutic change often occurs through shared experience of *being with* and the presence of the thinking mind of the ECMHS that reflects the depth and breadth of intersubjective processes. This offers a valuable framework for understanding the often-discrete emotional work involved with struggling parent-child dyads when early intersubjective experience has been challenged. Much of the ECMHS work takes place in this delicate space between what is known, what can be tolerated, and what must first find a place in someone else's mind to be felt and thought about; sitting in the unknown, rather than seeking certainty and definition.

It is evident that addressing the complexities of adverse childhood experience (and the interplay between neurodevelopmental sensitivity and relational experience) is far more difficult at a societal or public-health level than when framed as an individual issue. This creates a pull toward compartmentalising and individualising the problem as a diagnosis instead, which has the effect of shutting down thinking (including about how to therapeutically support those with autism); reinforced by the cultural lexicon around diagnosis, especially concerning neurodiversity, which serves as a tantalising pull towards oversimplifying complex human experience. The current political and economic climate is one in which we have seen years of austerity and devastating cuts to public services, as well as a global pandemic (the unique consequences of which are relevant but not addressed in this research study). Therefore, in this time of scant resource it would make sense that some parents feel strongly the need to fight for a diagnosis as the only means to get structured support for their child. The ECMHS are offering an approach to intervention that attends to the central experience and needs of children, regardless of neurodivergence, that are developmental and relational, but not always easy to think about.

7.2 Strengths

This study offers a valuable qualitative contribution to understanding how psychoanalytic theory can meaningfully inform work with children presenting with autism. It complements the breadth of existing research and psychoanalytic literature outlined in the review, particularly studies focused on the parent-child relationship. Across different perspectives, including organicist and behavioural approaches, developmental psychology and psychoanalytic theory, there is a convergence around the value of early relational intervention. The findings also connect closely with the growing body of research into parent-infant psychoanalytic psychotherapy led by CAPPs. However, a particular strength of this study is its focus on the work of ECMHS who are psychoanalytically informed professionals but not CAPPs. This highlights the broader reach of a potential workforce contributing in unique and important ways to support this population.

An important issue highlighted by this study is the ongoing lack of joined up working across the relevant services, which is a familiar issue, particularly when supporting vulnerable children and families. Clear and working systems, that enable all professional perspectives to contribute meaningfully to the assessment and care of these children, appear lacking. This is especially concerning for complex presentations that do not fit neatly into a diagnostic category like autism. The current structure tends to elevate the authority of diagnosing doctors, which makes it hard for relational and psychoanalytic insights offered by ECMHS to be recognised or integrated. This study aims to bring attention to the unique and valuable contribution that ECMHS can make, and the potential for their work to be more widely understood and included.

7.3 Limitations

This study involved a small group of five ECMHS from the same team and draws on their specific insights, which although they may resonate with others working in similar contexts, are an inevitable limitation to the findings. This is a limited range of perspectives and may have benefited from including participants from different teams, as the culture and thinking of a team as a group will to some degree have an influence on individual perspectives. The participants similar professional backgrounds or ways of thinking, much of which I align with, will have shaped the data in a particular way. Whilst I do not think this diminishes the value of the insights, it does mean the diversity of experience may be constrained, and that the findings are situated within this specific relational and professional context.

I wanted to focus was on this service provision area as it is where I am also working, capturing the richness and depth of their specific experience and how they apply psychoanalytic thinking in their work with these children and families, rather than produce findings that could be widely generalised. Reflexive Thematic Analysis emphasis in qualitative research prioritises depth and context over generalisability, allowing for a more detailed understanding of lived experience (Braun and Clarke, 2006).

Finlay (2002) highlights the importance of reflexivity in qualitative research, drawing attention to how both the researcher's standpoint and the characteristics of the sample can shape how findings are understood and interpreted. Whilst a reflexive approach in which my subjectivity as the researcher is an accepted and welcome part, it inevitably affects the reliability of the study as my own biases, assumptions, motivations and experiences will have influenced my approach as a whole and in the way in which I interpret and analyse the data.

Semi-structured interviews did allow for participants to speak freely and reflectively. At the same time the framing of my questions will have shaped the direction of thought, meaning the Interview Schedule may have been limiting. Slightly different questions may have elicited a broader and deeper range of responses, and different areas for thought could have come to light. For example, the experience and impact of the parental couple did not come into the responses, because it was not directly asked about. It might have been enriching to the findings to also consider the oedipal situation and its role in the development of psychic apparatus. The study was also limited by the fact that each participant was only interviewed once so it was not possible to follow up on any reflections or emerging thoughts that may have surfaced shortly afterwards, which may have further enriched and deepened the findings.

7.4 Scope for future research

There is scope for future research to explore parent-child work across a wider range of settings and teams; to better understand how psychoanalytic thinking is applied in diverse contexts and how it interacts with diagnostic systems. A different methodology to semi-structured interviews, that focused more on quantitative data of outcome measures could be very useful to add to the qualitative data. This could be further enhanced by Longitudinal Studies of outcomes, of both the children who followed the autism pathway and those that received parent-child intervention. This could contribute to an empirical evidence base for the outcomes of children presenting with autism who received a psychoanalytically informed intervention such as that offered by ECMHS or similar.

Finally, research that addresses the social, political and cultural context, such as the impact of austerity, reduced service provision, and systemic inequalities, could explore in more depth how structural factors shape both parental experience and professional practice. This could emphasise the importance of looking at how relational approaches can be sustained and valued within systems that increasingly rely on manualised, outcome-driven models of care.

8. References

Acquarone, S. (2007) *Signs of autism in infants: Recognition and early intervention*. London: Karnac Books.

American Psychiatric Association (2013) *Diagnostic and Statistical Manual of Mental Disorders (DSM-5)*. Washington, DC: American Psychiatric Association Publishing.

Association of Child Psychotherapists (ACP) (2018) *Response to the Health and Social Care Committee Inquiry into the First 1001 Days of Life*. Available at: https://childpsychotherapy.org.uk/news-media-0/acp-policy-reports-0/first-1001-days-life (Accessed: 12 September 2025).

Alvarez, A. (1992) *Live Company: Psychoanalytic Psychotherapy for Autistic, Borderline, Deprived and Abused Children*. London: Routledge.

Alvarez, A. (2016) 'Impaired interactions triggering defence or exposing deficit: Exploring the difference between the withdrawn and the "undrawn" autistic child', *Neuropsychoanalysis*, 18(1), pp. 3–7.

Avdi, E., Amiran, K., Baradon, T., et al. (2020) 'Studying the process of psychoanalytic parent-infant psychotherapy: Embodied and discursive aspects', *Infant Mental Health Journal*, 41, pp. 589–602.

Baradon, T., Avdi, E., Sleed, M., Salomonsson, B. and Amiran, K. (2023) 'Observing and interpreting clinical process: Methods and findings from "Layered analysis" of parent–infant psychotherapy', *Infant Mental Health Journal*, 44, pp. 691–704.

Barlow, J., Sleed, M. and Midgley, N. (2021) 'Enhancing parental reflective functioning through early dyadic interventions: A systematic review and meta-analysis', *Infant Mental Health Journal*, 42, pp. 21–34.

Beebe, B., Lachmann, F.M. and Jaffe, J. (1997) 'Mother–infant interaction structures and presymbolic self and object representations', *Psychoanalytic Dialogues*, 7(2), pp. 133–182.

Beebe, B., Jaffe, J., Markese, S., Buck, K., Chen, H., Cohen, P., Bahrick, L., Andrews, H. and Feldstein, S. (2010) 'The origins of 12-month attachment: A microanalysis of 4-month mother–infant interaction', *Attachment & Human Development*, 12(1–2), pp. 3–141.

Beebe, B., Lachmann, F., Markese, S. and Bahrick, L. (2012) 'On the origins of disorganized attachment and internal working models: Paper I. A dyadic systems approach', *Psychoanalytic Dialogues*, 22(2), pp. 253–272.

Bettelheim, B. (1967) *The Empty Fortress: Infantile Autism and the Birth of the Self*. Oxford: Free Press of Glencoe.

Bick, E. (1964) 'Notes on infant observation in psychoanalytic training', *International Journal of Psychoanalysis*, 45, pp. 184–188.

Bick, E. (1968) 'The experience of the skin in early object relations', *International Journal of Psychoanalysis*, 49(2–3), pp. 484–486.

Bion, W. (1962a) 'A psycho-analytic study of thinking', *International Journal of Psychoanalysis*, 43, pp. 306–310.

Bion, W. (1962b) *Learning from Experience*. London: Karnac.

Bion, W. (1979) *Attention and Interpretation. A scientific approach to insight in Psycho-analysis and groups*. London: Routledge.

Bowlby, J. (1988) 'The role of attachment in personality development', in *A Secure Base: Clinical Applications of Attachment Theory*. London: Routledge, pp. 119–136.

Bradshaw, J., Steiner, A., Gengoux, G. and Koegel, L. (2014) ‘Feasibility and effectiveness of very early interventions for infants at-risk for autism spectrum disorder: A systematic review’, *Journal of Autism and Developmental Disorders*, 45, pp. 778–794.

Braun, V. and Clarke, V. (2006) ‘Using thematic analysis in psychology’, *Qualitative Research in Psychology*, 3(2), pp. 77–101.

Braun, V. and Clarke, V. (2022) *Thematic Analysis: A Practical Guide*. London: SAGE.

Campbell, K., Ore, E., Durepos, P., Neguyen, L., Lin, L., Whitmore, C., Gehrke, P., Graham, L. and Jack, S. (2021) ‘Reflexive thematic analysis for applied qualitative health work’, *The Qualitative Report*, 26(6), pp. 2011–2028.

Davidson, C., Moran, H. and Minnis, H. (2022) ‘Autism and attachment disorders – how do we tell the difference?’, *BJPsych Advances*.

Dawson, G. (2008) ‘Early behavioural intervention, brain plasticity, and the early prevention of autism spectrum disorder’, *Development and Psychopathology*, 20, pp. 775–803.

Felitti, V.J., Anda, R.F., Nordenberg, D., Williamson, D.F., Spitz, A.M., Edwards, V. and Marks, J.S. (1998) ‘Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The Adverse Childhood Experiences (ACE) Study’, *American Journal of Preventive Medicine*, 14(4), pp. 245–258.

Field, T. (2002) ‘Early interactions between infants and their postpartum mothers’, *Infant Behaviour and Development*, 25(1), pp. 25–29.

Finlay, L. (2002) ‘“Outing” the researcher: The provenance, process, and practice of reflexivity’, *Qualitative Health Research*, 12(4), pp. 531–545.

Fonagy, P., Gergely, G., Jurist, E. and Target, M. (2002) *Affect Regulation, Mentalization and the Development of the Self*. New York: Open Press.

Gee, D., Cohodes, E., et al. (2021) ‘Influences of caregiving on development: A sensitive period for biological embedding of predictability and safety cues’, *Current Opinion in Psychology*, 43, pp. 1–6.

Gerhardt, S. (2015) *Why love matters. How affection shapes a baby’s brain.* London: Routledge.

Green, J., Wan, M., Guiraud, J., Holsgrove, S. et al. (2013) ‘Intervention for infants at risk of developing autism: A case series’, *Journal of Autism and Developmental Disorders*, 43(11), pp. 2502–2514.

Green, J., Pickles, A., Pasco, G., Bedford, R. et al. (2017) ‘Randomised trial of a parent-mediated intervention for infants at high risk for autism: Longitudinal outcomes to age 3 years’, *Journal of Child Psychology and Psychiatry*, 58(12), pp. 1330–1340.

Grier, F. (2019) ‘Musicality in the consulting room’, *International Journal of Psychoanalysis*, 100(5), pp. 827–851.

Hazlett, H., Munsell, C. et al. (2017) ‘Early brain development in infants at high risk for autism spectrum disorder’, *Nature*, 542, pp. 348–351.

Hobson, P. (2002) *The Cradle of Thought: Exploring the Origins of Thinking*. London: Macmillan.

Holloway, R. (2022) ‘High-functioning autism: Changes over 14 years of psychoanalytic psychotherapy: Part 3’, *Journal of Child Psychotherapy*, 48(1), pp. 6–29.

Hollway, W. and Jefferson, T. (2013) *Doing Qualitative Research Differently: A Psychosocial Approach*. 2nd edn. London: SAGE.

Jaswal, J. and Wozniak, R. (2019) ‘Being versus appearing socially uninterested: Challenging assumptions about social motivation in autism’, *Behavioural and Brain Sciences*, 42, pp. 1–24.

Jones, E., Dawson, G., Kelly, J., Estes, A. and Webb, S. (2017) ‘Parent-delivered early intervention in infants at risk for ASD: Effects on electrophysiological and habituation measures of social attention’, *Autism Research,* 10(5), pp. 961 – 972.

Kanner, L. (1943) ‘Autistic disturbances of affective contact’, *Nervous Child*, 2, pp. 217–250.

Klauber, T. and Rhode, M. (2004) *The Many Faces of Asperger's Syndrome*. Tavistock Clinic Series. London: Routledge.

Klein, M. (1959) ‘Our adult world and its roots in infancy’, in *The Writings of Melanie Klein*, Vol. 3. London: Vintage, 1997, pp. 176–235.

Lord, C., Rutter, M., DiLavore, P.C., Risi, S., Gotham, K. and Bishop, S. (2012) *Autism Diagnostic Observation Schedule, Second Edition (ADOS-2)*. Torrance, CA: Western Psychological Services.

Lord, C., Brugha, T., Charman, T. et al. (2020) ‘Autism spectrum disorder’, *Nature Reviews Disease Primers*, 6(1), pp. 1–23.

Lyons-Ruth, K. (1999) ‘The two-person unconscious: Intersubjective dialogue, enactive relational representation, and the emergence of new forms of relational organization’, *Psychoanalytic Inquiry*, 19(4), pp. 576–617.

Lyons-Ruth, K. (2007) ‘The interface between attachment and intersubjectivity: Perspective from the longitudinal study of disorganized attachment’, *Psychoanalytic Inquiry*, 26(4), pp. 595–616.

Modabbernia, A., Velthorst, E. and Reichenberg, A. (2017) ‘Environmental risk factors for autism: An evidence-based review of systematic reviews and meta-analyses’, *Molecular Autism*, 8(1), pp. 1–16.

MacLeod, J. and Perepa, P. (2020) ‘Early years practitioners’ knowledge of early signs of autism in England’, *Support for Learning*, 35(2), pp. 192–204.

May, T. (2001) *Social Research: Issues, methods and process*. 3rd edn. Buckingham: Open University Press.

McGilchrist, I. (2009) *The Master and His Emissary: The divided brain and the making of the Western world*. New Haven and London: Yale University Press.

McKenzie, R. and Dallos, R. (2017) ‘Autism and attachment difficulties: Overlap of symptoms, implications and innovative solutions’, *Clinical Child Psychology and Psychiatry*, 22(4), pp. 632–648.

McLeod, J. (2015) *Doing Research in Counselling and Psychotherapy*. 3rd edn. London: SAGE.

Meltzer, D., Bremner, J., Hoxter, S., Weddell, D. and Wittenberg, I. (1975/2018) *Explorations in Autism: A psychoanalytic study*. London: The Harris Meltzer Trust.

Miltz, S., Pennicott-Banks, E., Avdi, E. and Baradon, T. (2023) ‘Addressing the baby and atypical maternal behaviour in psychoanalytic parent-infant psychotherapy’, *Journal of Child Psychotherapy*, 49(2), pp. 179–190.

Mitrani, J. (2010) ‘Minding the gap between neuroscientific and psychoanalytic understanding of autism’, *Journal of Child Psychotherapy*, 36(3), pp. 240–258.

Moran, H. (2010) ‘Clinical observations of the differences between children on the autism spectrum and those with attachment problems – the Coventry Grid’, *Good Autism Practice*, 18(1), pp. 62–80.

Muir, E. (1992) ‘Watching, waiting, and wondering: Applying psychoanalytic principles to mother-infant intervention’, *Infant Mental Health Journal*, 13(4), pp. 319–328.

Muratori, F. and Apicella, F. (2022) ‘Being born autistic and the forming of the interpersonal world’, *A Topical Journal for Mental Health Professionals*, 42(1), pp. 6–22.

Music, G. (2017) *Nurturing Natures: Attachment and children's emotional, sociocultural and brain development*. 2nd edn. London and New York: Routledge.

Music, G. (2021) ‘Resparking from flatness: New thoughts on shut-down states after trauma and neglect’, *Journal of Child Psychotherapy*, 47(3), pp. 357–375.

National Institute for Health and Care Excellence (2011) *Autism: Recognition, referral and diagnosis of children and young people on the autistic spectrum*. NICE guideline CG128. Available at: https://www.nice.org.uk/guidance/cg128 (Accessed: 12 September 2025).

National Institute for Health and Care Excellence (2013) *Autism spectrum disorder in under 19s: Support and management*. Available at: https://www.nice.org.uk/guidance/cg170 (Accessed: 12 September 2025).

NHS (2018) ‘Funding boost for new mums’ mental health’. Available at: https://www.england.nhs.uk/2018/02/funding-boost-for-new-mums-mental-health/ (Accessed: 12 September 2025).

O’Shaughnessy, E. (1964/2018) ‘The absent object’, *Journal of Child Psychotherapy*, 42(2), pp. 208–217.

Perry, B.D., Pollard, R.A., Blakley, T.L., Baker, W.L. and Vigilante, D. (1995) ‘Childhood trauma, the neurobiology of adaptation, and “use-dependent” development of the brain: How “states” become “traits”’, *Infant Mental Health Journal*, 16(4), pp. 271–291.

Perry, B.D., Hambrick, E.P., Brawner, T.W., Brandt, K., Hofmeister, C. and Collins, J. (2018) ‘Beyond the ACE score: Examining relationships between timing of developmental adversity, relational health and developmental outcomes in children’, *Infant Mental Health Journal*, 39(3), pp. 223–234.

Pilgrim, D. and Vassilev, I. (2010) *Examining Trust in Healthcare: A multidisciplinary perspective*. Basingstoke: Palgrave Macmillan.

Piontelli, A. (1992) *From Foetus to Child: An observational and psychoanalytic study*. London: Tavistock/Routledge.

Popay, J., Roberts, H., Sowden, A., et al. (2006) *Guidance on the conduct of narrative synthesis in systematic reviews*. ESRC.

Raphael-Leff, J. (2007) ‘Introduction’, in Acquarone, S. (ed.) *Signs of Autism in Infants: Recognition and early intervention*. London: Karnac Books.

Reid, S. (1999) ‘Autism and trauma: Autistic post-traumatic developmental disorder’, in Alvarez, A. and Reid, S. (eds.) *Autism and Personality: Findings from the Tavistock Autism Workshop*. London: Routledge.

Rhode, M. (1989) ‘Some observations on autistic states’, *Journal of Child Psychotherapy*, 15(1), pp. 21–41.

Rhode, M. (1997) ‘The psychotic and autistic child’, in Urwin, C. and Sternberg, J. (eds.) *The Handbook of Infant, Child and Adolescent Psychotherapy*. London: Routledge, pp. 155–170.

Rhode, M. (2007) ‘Helping toddlers to communicate: Infant observation as an early intervention’, in Acquarone, S. (ed.) *Signs of Autism in Infants: Recognition and Early Intervention*. London: Karnac Books.

Rhode, M. and Grayson, K. (2021) ‘An observationally and psychoanalytically informed parent-toddler intervention for young children at risk of ASD: An audited case series and convergences with organicist approaches’, in Fitzgerald, M. (ed.) *Autism Spectrum Disorder – Profile, Heterogeneity, Neurobiology and Intervention*. London: InTechOpen.

Roman-Urrestarazu, A., van Kessel, R., Allison, C., Matthews, F.E., Brayne, C. and Baron-Cohen, S. (2021) ‘Association of race/ethnicity and social disadvantage with autism prevalence in 7 million school children in England’, *JAMA Pediatrics*, 175(6).

Rutter, M., Andersen-Wood, L., Beckett, C., Bredenkamp, D., Castle, J., Groothues, C., Kreppner, J., Keaveney, L., Lord, C. and O'Connor, T.G. (1999) ‘Quasi-autistic patterns following severe early global privation’, *Journal of Child Psychology and Psychiatry*, 40(4), pp. 537–549.

Sadiq, F.A., Slator, L., Skuse, D., Law, J., Gillberg, C. and Minnis, H. (2012) ‘Social use of language in children with reactive attachment disorder and autism spectrum disorders’, *European Child & Adolescent Psychiatry*, 21(5), pp. 267–276.

Satterstrom, F., Kosmicki, J., Wang, J. et al. (2020) ‘Large-scale exome sequencing study implicates both developmental and functional changes in the neurobiology of autism’, *Cell*, 180(3), pp. 568–584.e23.

Sutton, S. (2020) *Psychoanalysis, neuroscience and the stories of our lives. The relational roots of mental health.* London: Routledge.

Singletary, W.M. (2015) ‘An integrative model of autism spectrum disorder: ASD as a neurodevelopmental disorder of experienced environmental deprivation, early life stress and allostatic overload’, *Neuropsychoanalysis*, 17(2), pp. 81–119.

Smith, J.A., Flowers, P. and Larkin, M. (2009) *Interpretative Phenomenological Analysis: Theory, Method and Research*. London: Sage.

Spikol, A., McAteer, D. and Murphy, J. (2019) ‘Recognising autism: A latent transition analysis of parental reports of child autistic spectrum disorder “red flag” traits before and after age 3’, *Social Psychiatry and Psychiatric Epidemiology*, 54(6), pp. 703–713.

Spoladore, A. (2013) ‘A young boy grows away from autism 1’, *Journal of Child Psychotherapy*, 39(1), pp. 22–38.

Stern, D.N. (1985) *The Interpersonal World of the Infant: A View from Psychoanalysis and Developmental Psychology*. New York, NY: Basic Books.

Stern, D.N. (1998) ‘The process of therapeutic change involving implicit knowledge: Some implications of developmental observations for adult psychotherapy’, *Infant Mental Health Journal*, 19, pp. 300–308.

Tronick, E.Z., Als, H., Adamson, L., Wise, S. and Brazelton, T.B. (1978) ‘The infant's response to entrapment between contradictory messages in face-to-face interaction’, *Journal of the American Academy of Child Psychiatry*, 17(1), pp. 1–13.

Tronick, E.Z. (1989) ‘Emotions and emotional communication in infants’, *American Psychologist*, 44(2), pp. 112–119.

Tronick, E. and Beeghly, M. (2011) ‘Infants’ meaning-making and the development of mental health problems’, *American Psychologist*, 66(2), pp. 107–119.

Tubb, A. (2021) ‘Suicide remains the leading cause of direct maternal death in first postnatal year’, *Maternal Mental Health Alliance*. Available at: https://maternalmentalhealthalliance.org/news/mbrrace-suicide-leading-cause-maternal-death/ (Accessed: 12 September 2025).

Tustin, F. (1992) *Autistic States in Children*. Oxon: Routledge.

Tustin, F. (2008) ‘A significant element in the development of psychogenic autism’, in Barrows, K. (ed.) *Autism in Childhood and Autistic Features in Adults*. London: Karnac Books.

Waddell, M. (2002) *Inside Lives: Psychoanalysis and the Growth of the Personality*. London: Routledge.

Wan, M., Green, J., Elsabbagh, M., Johnson, M. et al. (2013) ‘Quality of interaction between at-risk infants and parent at 12–15 months is associated with 3-year autism outcome’, *Journal of Child Psychology and Psychiatry*, 54(7), pp. 763–771.

Whitehouse, A., Varcon, K., Pillar, S., Billingham, W. et al. (2021) ‘Effects of pre-emptive intervention on developmental outcomes among infants showing early signs of autism’, *JAMA Pediatrics*, 175(11), pp. 1–11.

Winnicott, D.W. (1960) ‘The theory of the parent-infant relationship’, *International Journal of Psychoanalysis*, 41, pp. 585–595.

Zietlow, A.-L., Nonnenmacher, N., Reck, C., Ditzen, B. and Müller, M. (2019) 'Emotional stress during pregnancy – Associations with maternal anxiety disorders, infant cortisol reactivity, and mother–child interaction at pre-school age', *Frontiers in Psychology*, 10, 2179.

9. Appendices

Appendix A - Recruitment Email

Dear Colleague

I would like to invite you to take part in my research project as part of my Professional Doctorate Qualification in Child and Adolescent Psychoanalytic Psychotherapy, with the Tavistock and Portman, accredited by the University of Essex.

The title is:

The interrelationship between brain, mind, and relational experience: Psychoanalytic work with families attending Under-5 CAMHS to help for their potentially autistic child.

Please let me know if you are interested and I can send you more detailed information about the project and participation.

Many thanks

Ursula Smith

Appendix B - Participant Information Sheet

The Tavistock and Portman NHS
NHS Foundation Trust

The interrelationship between brain, mind, and relational experience: Psychoanalytic work with families attending Under-5 CAMHS to help for their potentially autistic child.

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.

What is the purpose of this study?

As part of this study I want to explore how clinicians think and work psychoanalytically with children, their families and networks when there is an autism diagnosis or when autism is being considered

Who is conducting the study?

My name is Ursula Smith.

I am a researcher working for Avon and Wiltshire NHS Trust and training to be a Child and Adolescent Psychotherapist at The Tavistock and Portman Centre. 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 proposed research project aims to explore what it is like as a professional working within a psychoanalytic framework with children under the age of 5, their families and the professional network when trying to make sense of a complex presentation. I am particularly interested to think about this when there is a pull towards a more absolute and concrete way of understanding this presentation by parents and other professionals. I propose that psychoanalytic theory can offer an in-depth understanding of the complexities of an autistic presentation (both when there is the presence of a neurodevelopmental condition and when there is not thought to be).

There is considerable research literature into the differing viewpoints on autism - what it is, its aetiology and how it can or should be 'treated'. It is now widely thought of by professionals and researchers across the sectors as a highly complex condition, which is both neurodevelopmental and influenced by environmental factors. Research also evidences that a presentation of autistic like traits may also relate to early environmental difficulties such as early attachment experiences, including experiences of developmental trauma, abuse and neglect. Psychoanalysts talk about a non-organic autistic state of mind and differentiates between organic autism being a result of damage to the brain, whilst 'psychogenic' autism a result of damage to the psyche. There is emerging research into the efficacy of early intervention with the parent/child relationship that promotes connectivity, which seems to reduce the likelihood that a child is diagnosed with autism at age 3 (Green et al 2017). This fits with research increasingly showing a convergence between organicist and psychoanalytic approaches, when traditionally they have been at odds.

It is a key research recommendation in NICE autism recognition, referral and diagnosis guidelines (2011: 1.4) that proper training is required to recognise autism early on and practitioners who are able to differentiate between autism as a neurodevelopmental condition and as a response to environmental experience. The early childhood mental health specialist (ECMHS) service is offering an in-depth way of thinking and understanding children age 0 – 5 through their emotional and interpersonal experience, at the same time as taking into account neurodevelopmental factors. This can be challenging when faced with the anxiety of others and defensive thinking about a perplexing and hard to reach child.

Therefore, given the complexity of understanding both the diagnosable neurodevelopmental condition of autism and concept of autistic traits and state of mind, alongside the importance of early identification and intervention (for both presentations) this research is very topical and hopefully will be useful to the thinking and effective working with these children.

What will participating in this project involve?

You will be invited to take part in an individual interview. This will mainly be for you to talk freely about the topic with some prompts from myself. During the discussion I would be interested to hear about how you think about (from your training and experience clinically) issues around autism and children with complex presentations, and what your personal experience is of working clinically with this group of young people.

All interviews will last between 60 and 90 minutes and will be audio recorded. These interviews will be conducted face to face and take place at your usual place of work to try and suit everyone involved.

No extension to your usual working hours will be necessary.

Do I have to take part?

No, it is completely your choice whether or not you take part in the study. If you agree to take part, you can withdraw without giving any reason at any time up to three weeks after the interview. This timescale has been decided as the data will then be being processed and analysed. If you decide to withdraw all data collected or about you it will be destroyed immediately.

Criteria to take part in the study:

- Currently working for the Early Childhood Mental Health Specialist Team [Pseudonym] for [Locality] NHS Trust’s Child and Adolescent Mental Health Service.
- At least one years’ experience within a CAMHS team.
- Acquired the M7/M9 or equivalent psychoanalytic infant observation course to postgraduate diploma level.
- Have previous or current experience of working with children where autism is being considered, but there is also a complex early life context.

What will happen to any information I give?

The Tavistock and Portman NHS Foundation Trust is the sponsor for this study based in the United Kingdom. I will be using information from you to undertake this study and will act as the data controller for this study. This means that I am responsible for looking after your information and using it properly. I will keep identifiable information about you from this study for 5 years after the study has finished. The interview will be audio recorded and transcribed by myself.

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

Quotes from the transcript will be used in the write up of the project but these will be de-identified. However, please note, it is possible that other colleagues who know you well may recognise you in some of the quotes used, although every effort will be made to prevent this. Any extracts from what you have said that are quoted in the research report will be entirely anonymous.

All electronic data will be stored on a password protected computer. Any paper copies will be kept in a locked filing cabinet. All audio recordings will be destroyed after completion of the project. Other data from the study will be retained, in a secure location, for 5 years.

If you would like more information on the Tavistock and Portman and GHC privacy policies please follow these links:

https://tavistockandportman.nhs.uk/about-us/contact-us/about-this-website/your-privacy/

https://www.ghc.nhs.uk/privacy-notice/

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

There will be limitations to the confidentiality of information provided if it is deemed yourself or someone else is at risk.

What will happen to the results of the project?

The results of this study will be used in my Research Dissertation Project and Doctorate qualification. It may also be used in future academic presentations and publications.

I would be happy to send you a summary of the results if you wish. Please contact me to request this if it of interest to you.

What are the possible benefits of taking part?

There will be no direct benefits for you. However, by taking part you will be given the opportunity to consider this growing area of practise. It is hoped that it will provide a space for you to consider and reflect on your experience in a way that may be helpful for future work.

Are there any risks?

No, there are no direct risks. However, I am aware that it may be a challenging topic that involves possible unconscious beliefs which some may find uncomfortable. If needed details of a confidential service you can access will be provided.

Contact details

I am the main contact for the study. If you have any questions about the project or would like to discuss this further please don't hesitate to contact me. My contact details are:

Ursula Smith

Email: ursula.smith3@nhs.net

Telephone: …….

Address: …….

Alternatively, any concerns or further questions can be directed to my supervisor:

Dr Judy Shuttleworth

Email: judyshuttleworth@hotmail.com

If you have any concerns about the conduct of this research, the researcher or any other aspect of this research project please contact Helen Shaw, Head of Academic Governance and Quality Assurance (academicquality@tavi-port.nhs.uk).

Thank you for considering taking part in this study and taking the time to read this information. If you are willing to take part in the research please complete the consent form provided

Appendix C - Consent Form

Project title: The interrelationship between brain, mind, and relational experience: Psychoanalytic work with families attending Under-5 CAMHS to help for their potentially autistic child.

Name of researcher: Ursula Smith

- 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 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 it is my responsibility to anonymise any examples referring to cases I chose to discuss during the interview. ☐
- 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: Ursula Smith Email: ursula.smith3@nhe.net

Supervisor : Dr Judy Shuttleworth Email: judyshuttleworth@hotmail.com

Participant's Name (Printed):___________________________________

Participant's signature:____________________________ Date:____________

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

Appendix D - Semi-structured interview schedule

The Tavistock and Portman NHS
NHS Foundation Trust

Title: The interrelationship between brain, mind, and relational experience: Psychoanalytic work with families attending Under-5 CAMHS to help for their potentially autistic child.

Welcome: explanation of it being a semi-structured interview lasting between 60 and 90 minutes. Remind them that they are welcome to talk freely about the topic of how the think about and have experienced the topic in their clinical work. Explain that they can discuss specific cases (past and present) that may feel relevant. Remind about anonymising using pseudonyms s or initials when discussing cases. Ask for professional background and training.

Autism:

- How would you describe Autism? (Given private or shared opinion) – probe, what do you look out for?
- What is your understanding of it/what it stems from - aetiology?
- Based on your training and experience, how do you think about it and does that make any difference?
- How might this compare to ways other might think about it - is there a contrast?

Your experience:

- How has this come up in your work? Frequency? Level of need/concern?
- What sense do you make of this?
- Case examples? How they work – ones which have or haven't received a diagnosis
- Challenges – have you ever encountered a situation where the presentation seems more open (features but not diagnosis)/complex/mixed presentation?
- What interventions – how do you successful intervene

Experience of parent and professional network

- What is your understanding of why parents seek out a diagnosis
- What is your understanding of why professionals seek out a diagnosis
- What are the barriers to thinking about complexities/mixed aetiology?
- What has worked? What is helpful?
- What has not worked or has been difficult?
- What would a diagnosis offer them?
- Case examples

Working with child and family:

- What has it been like to work with a child or children with complex presentations?
- How has it been for you during sessions? Gut feelings/intuition/overt responses
- How has it left you feeling following sessions?
- What has been like working with the family around them?
- What has it been like to work with ECMHS?

Future:

- Now reflecting on that, how does it feel?
- What might help or benefit you when working with these cases in the future?
- What do you think is needed in this area of work in general?

End:

- If gave shared opinion to defining Autism or autistic state of mind, ask to describe again in own words.
- 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 colleagues, supervisors and senior staff who are within the clinic at that time if they need support following the interview discussion. Send debrief out to them.

Appendix E - TREC Approval

Dear Ursula,

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

The assessor did make a minor recommendation – please see below:

Note that if you have consent and they have passed the withdrawal point then anonymised data used for publication should not require an additional consent prior to publication(s) – seek this at consent point (unless as you state there are identifiable features

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

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

Your approved TREC application is attached

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

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

Regards,

Paru

Mrs Paru Jeram

Senior Quality Assurance Officer

Academic Governance and Quality Assurance

https://tavistockandportman.nhs.uk/research-and-innovation/doing-research/student-research/

Appendix F - Debrief Letter

Dear….

I am writing to thank you for your contribution to my Doctoral Research Project. I hope you found it as interesting as I did.

If following taking part there are any issues that are concerning you, I hope that you can access the support network around you (colleagues, supervisor and managers). However, if this is not possible there is a confidential counselling service provided by [Locality] NHS Trust:

You can self refer as follows:

Call Support Network on ……. or fill out a referral form through the website …..

If you have any questions or would like further information here are my contact details:

Email: ursula.smith3@nhs.net

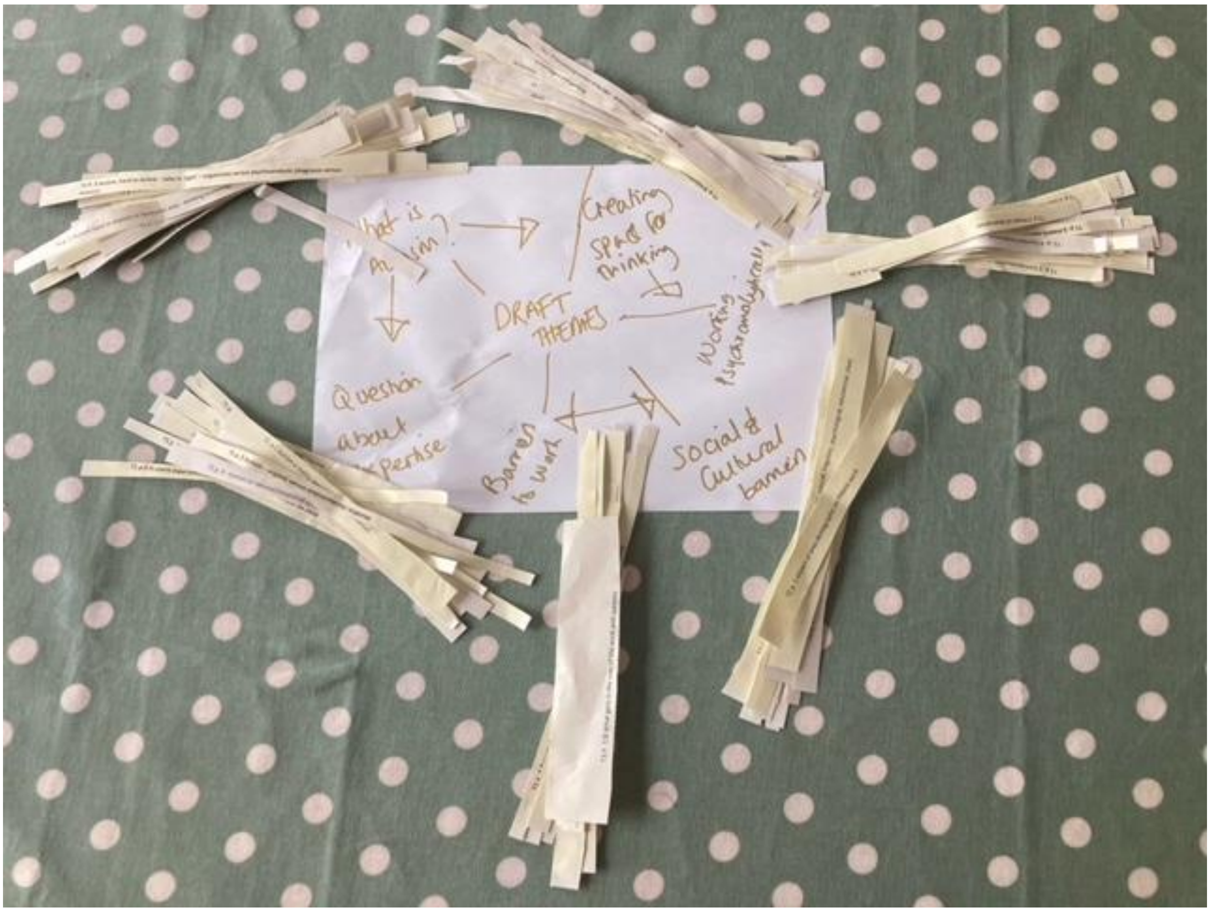
Phone:

If you have any concerns about how the study has been conducted please contact myself, my supervisor Dr Judy Shuttleworth (judyshuttleworth@hotmail.com) or Lisa Harris, Head of Academic Governance and Quality Assurance (academicquality@tavi-port.nhs.uk).

Kind regards,

Ursula Smith

Appendix G – Theme generation


What is Autism?
Creating Space for thinking
DRAFT THEMES
Working psychoanalytically
Question about expertise
Barriers to work
Social & Cultural barriers