What is the experience of Watch Me Play! for caregivers and professionals for young children in care who have emerging neurodivergent development and are supported by an Under-fives Mental Health Service?

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Abstract

Young children in care with emerging neurodivergent development (ND) are a vulnerable population who are under-represented in research. Watch Me Play! (WMP) is a psychoanalytically informed approach to promoting child-led play through supporting attuned caregiver attention. Engaging in play promotes learning and development and play is a fundamental motivator for children because it is inherently pleasurable and meaningful. However, for children in care with emerging ND, play can be more difficult. Caregivers and professionals can find their play confusing, frustrating and disturbing. This can further inhibit these children's capacities and opportunities for child-led play to be experienced and to develop. This qualitative study aimed to better understand the experience of WMP for caregivers and professionals for young children in care with emerging ND. Three core themes were generated by analysing data, using Reflexive Thematic Analysis, from seven semi-structured interviews with caregivers and professionals. Theme one – how WMP is understood; theme two – potential benefits of WMP; and theme three – challenges and difficulties of WMP. The study proposed various implications for practice. Recommendations for future research included further exploration of WMP with children with emerging ND and autism; the experience and challenges of child-led play with children with emerging ND; the experience of WMP during transition from foster care to adoption; and the experience of WMP training for social workers, foster carers and adoptive parents.

Key words: neurodivergent development, autism, under-fives, children in care, play, foster care, adoption, transitions, professional networks, children's social care, social work, parent-infant relationships.

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There are many others who I extend my gratitude to, for the moments of inspiration shared; for their time, attention and guidance; and for their endless patience, understanding and encouragement – Katie, Rajni, my family, friends and colleagues.

Dedication

To my big brother – our relationship inspired me to find ways to support young children most at risk of being overlooked, unseen and unsupported.

Declaration

I hereby declare that the contents of this thesis are entirely my own and all other sources included have been cited throughout and collated in the reference list. This study received ethical approval from Tavistock Research and Ethics Committee.

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Thesis Structure

The **Introduction** presents the aims, objectives, rationale and inspiration for the study. I will contextualise Watch Me Play! (Wakelyn, 2019) (WMP) and the under-fives service where the research took place. I will describe the cohort of children considered and the participants interviewed.

The **Literature Review** addresses four areas of research:

- Mental health services and support for young children in care with emerging neurodivergent development (ND),
- Origins and defining characteristics of the WMP approach,
- Young children in care, exploring both emerging ND and experiences of transition,
- Complexities in the work of professional networks.

The **Methods** section locates this qualitative, exploratory study, using Reflexive Thematic Analysis (RTA) (Clarke & Braun, 2021), within the critical realist paradigm. I provide a researcher reflexivity statement, justify recruitment and sampling of participants and describe the processes of data collection and data analysis.

The **Findings** presents the three core themes and subthemes, illustrated with extracts from the data.

The **Discussion** links the findings with the literature.

The **Conclusion** gives a summary of findings, discusses strengths and limitations, formulates implications for practice and recommendations for further research.

Key Terms and Definitions

The term **emerging neurodivergent development** relates to undiagnosed developmental differences in young children. Walker (2021) describes neurodiversity as unique and naturally occurring differences in individual minds, whereas 'neurodivergence' represents a significant variation from the typical functions of the brain (Walker, 2021). 'Emerging ND' encompasses a range of neurodevelopmental differences, such as, attention deficit hyperactivity disorder (ADHD) and Foetal Alcohol Spectrum Disorder (FASD). The children in this study all experienced emerging ND indicative of autism.

The term **caregiver** takes account of diverse family constellations. Foster carers are often considered professional parents and could be recognised as professionals. I am considering foster carers as caregivers, like adoptive parents, because they provide

WMP with the child. Other professionals, such as social workers, are part of the network but do not provide WMP support themselves.

The term **professional** refers to adults who work with the child in a professional capacity. All the professionals who took part in this study were social workers.

The term **professional network** describes a group of professionals who work together in the child's interests and make decisions about the child's care.

The term **in care** refers to children removed from the care of birth parents into the care of a local authority. In this study, all children were in foster care at the beginning of the study. Two moved to adoption – one during the period of the study and one after the study was completed.

Introduction

This qualitative study explores the experience of WMP for caregivers and professionals for young children under five who are in care and present with emerging ND. Participants come from two groups – caregivers (foster carers and an adoptive parent) and professionals (social workers). Data has been collected through semi-structured interviews and RTA has been used to analyse the data.

i. Watch Me Play!

WMP is a psychoanalytically informed therapeutic intervention initially designed to support relationship building between foster carers and the baby or young child in their care. In recent years WMP has been used more widely. The approach involves a caregiver spending a short time (up to 20 minutes) with their child, promoting child-led play with a selection of simple, non-electronic toys. Other distractions are limited: the television is off, and mobile phones put away. Caregivers are encouraged to get alongside their child and watch their play – being curious, following their child's lead and talking with their child about their play. This approach remains the same however limited the child's play appears.

WMP promotes undivided adult attention. This can be challenging for some caregivers and, where possible, caregivers are supported by a WMP practitioner. Together they observe the child's play. The WMP practitioner encourages the caregiver to talk to their child about their play. After, they discuss what they saw and the caregiver's experience of watching the child's play. Focus is given to noticing changes,

developments or consistent trends in the child's play and looking for ways to manage challenges presented by the approach.

ii. Children in care with emerging ND

Young children enter the care system for various reasons. They are likely to have experienced maltreatment, abuse and neglect, often at the hands of caregivers, and disruptions to their caregiving relationships.

Young children in care may have experienced physical and emotional distress in utero. Some infants experience extremely high levels of stress, including domestic abuse, and some are born withdrawing from alcohol or other medication and drugs. Research indicates links between prenatal stress and birth complications, lower birth weight and prematurity. Recent studies show that stress and trauma can affect physiology in utero and following birth. High levels of prenatal stress and experiences of trauma and neglect are linked to changes in the foetus's brain structure and later neurodevelopmental issues (Music, 2024).

Young children in care are deprived of the ordinary positive parenting and family experiences needed to grow and develop. They may find it hard to make use of stability and care in their foster family which can increase relational difficulties. When children move between several caregivers it becomes more difficult to keep their story alive in caregivers' minds. This can make it hard to reflect on possible meanings of their behaviour, impeding experiences of connection and feeling understood.

There are similarities in the developmental, relational and behavioural presentations of young children who have experienced maltreatment, neglect, abuse, and disruption

to their caregiving relationships and of young children with autism. Additionally, it can be more difficult for caregivers to attune to their infant or young child with emerging ND, which can create further relational difficulties. Early adversity can lead to relationships feeling less safe and trustworthy. Infants and young children adapt to manage difficult and threatening environments. These adaptations can appear like developmental, relational and behavioural presentations indicative of autism.

Researchers (Moran, 2010; Flackhill et al. 2017) have attempted to summarise the differences between social communication difficulties seen in children with autism and children who have experienced early adversity.

iii. Autism assessment and support for young children with emerging ND

According to a recent report (NHS England, 2023), approximately 66% of children referred to neurodevelopmental services and 75% of children who are assessed receive a diagnosis of autism (Venkat et al., 2024). This report states that autism assessment teams should be multidisciplinary, well-led, and made up of qualified staff. The pathway should include five stages: identification and referral, screening and triage, pre-assessment support, autism assessment, and post-assessment support.

In the area where this study was conducted, the Multiagency Autism Assessment Team (MAAT) pathway is delivered by a multidisciplinary Child and Adolescent Mental Health Service (CAMHS). Children are referred by their education provider and not accepted onto the pathway until they are five. As suggested by NHS England (2023), the pathway includes an identification and referral stage, followed by screening and triage, followed by the offer of support from a Parent Infant Mental Health Service

(PIMHS) for all referrals of under-fives. If the child would benefit from a MAAT assessment and does not have coexisting mental health or relational needs, they are accepted onto the pathway once they are five years old. In the meantime, support for younger children can be accessed from health, education, care and third sector services (Appendix A).

For a child with suspected social communication difficulties, education settings are required to complete a twelve-week pre-referral social communication programme. A decision is then made as to whether a full autism assessment is needed. There is a wait of several years for an autism assessment which is completed using the Autism Diagnostic Observation Schedule (ADOS) and through collecting a detailed developmental history. Other supporting assessments are completed where needed e.g. cognitive assessments, Coventry grid interview (Flackhill et al., 2017). There is a further wait for feedback of around 6 months. There is no further support from this service which only provides assessment. Coexisting mental health needs are supported by CAMHS and/or third sector services.

iv. Aims and objectives of this study

I wanted to better understand the experience of WMP for young children with emerging ND, and their caregivers, and professional networks. At the stage of recruitment, all the caregivers I recruited were foster carers. In the knowledge that WMP was originally designed for use with children in care, this sample was considered suitable for the study. My initial aim to focus solely on young children with emerging ND was not possible and remains an interesting area for further research. I adapted the research question and objectives to take account of the nature of this cohort.

The research objectives are to explore:

- The experience of WMP for caregivers of young children in care with emerging ND,
- Challenges that WMP may present for caregivers of young children in care with emerging ND,
- The contribution of WMP, if any, to the work of professional networks for young children in care with emerging ND.

v. Researcher, service and participant context

When I began this project, I was a Child and Adolescent Psychoanalytic Psychotherapist in Clinical Training, based in PIMHS where the research took place. Since then, I have qualified and joined the team as a permanent member, I also work in a separate team within CAMHS that works in partnership with Children's Social Care, to support families who might be experiencing developmental trauma and whose children are not in care. This role has informed a deeper understanding of the importance of, and complexities involved in, partnership working within professional networks that can become fractured and disintegrated (Bevington & Dangerfield, 2024).

Caregivers who were interviewed for the study were supported by PIMHS, which forms part of a multidisciplinary CAMHS in north-west England. The service provides support with relationship building to parents and carers antenatally or with their baby or young

child aged up to five years. This service has been established since 2007 and is the longest standing PIMHS in the borough. In this borough there is an integrated perinatal and parent-infant mental health service strategy (Jones & Lee, 2020) which guides the work of the service. The clinical approach of these PIMHS teams is informed by psychoanalytic and attachment theory, neuroscience and child development research.

Participants were caregivers and professionals for three young children aged between one and four years. Each child had at least six sessions of WMP with their caregiver, facilitated by me – in my role as a WMP practitioner within PIMHS.

vi. Inspiration

RTA encourages researchers to interrogate and articulate their own subjective position as researcher. To do this, it is important to share the inspiration for my choice of question, which is influenced by my professional background and my upbringing.

When I was growing up, I saw my older brother struggling – with learning and development and with relationships – much more than I seemed to. This had a profound impact on me that I did not fully understand until I was older, and through psychoanalysis. I recognise that this experience sparked an early and ongoing commitment to children and families, particularly those most at risk of being missed by usual channels of support.

I began working with children and families as an Early Years Practitioner and subsequently as a Portage Home Visitor. I developed an interest in working with young children with developmental delay and emerging ND. I noticed these children sometimes appeared lost, not part of a group, not noticed by adults and peers, and

sometimes were highly distressed. They struggled to be involved with both nursery and family life. It appeared that establishing meaningful, relational connection was challenging for these children. Their play could be limited and repetitive and sometimes it was hard to recognise any meaning in their play. I realised that watching, waiting, and playing alongside these children could sometimes allow meaningful relationships to grow. I noticed that development that had appeared stuck began to change after some time of being together in this way.

When I discovered WMP, whilst training as a Child and Adolescent Psychotherapist, the approach resembled what I had found helpful in previous roles. Two aspects struck me most: firstly, how fundamental it is for young children to experience emotional connection with their caregivers, especially when there is emerging ND; secondly, how important it is to bring the child's experience to life, for caregivers and for professional networks who make decisions about children with complex needs, often with little awareness or recognition of the child's emotional experience.

vii. Rationale

Children in care with emerging ND face compounded challenges. Parsons and colleagues (2019) explain that educational outcomes for looked-after children with autism are significantly poorer than for autistic children who are not in care, and worse than for most groups of looked-after children with special educational needs in England. This highlights the critical need for focused attention on this highly vulnerable population.

Children need to express themselves and develop meaningful relationships. Play is one way to do this. For young children with emerging ND there can be a focus on behaviour which may be disruptive, withdrawn or shutdown. Play, and playing with others, may not be straightforward for these children. Both caregivers and professionals, may tend to see children and their play only through the lens of ND, for example, ‘he plays like this because he’s autistic’. There may be little, or no, space to consider other aspects of the child and/or the child-caregiver relationship. Yet, tracing back in the child’s life, it is likely there were difficulties and needs arising in their earliest relationships.

Caregivers are often full of anxiety which might be articulated in ways such as, ‘what is wrong with my child?’ and professional networks can become fractured and lose sight of the child’s experience under the impact of these anxieties. The child’s play may then be considered less important, and their play becomes vulnerable to being stripped of its meaning. This can lead to adults feeling less curious and even excluded from the child’s play. There can, instead, be a focus upon behavioural management and teaching new skills. WMP offers opportunities to observe play, share observations and reflect, which can create a space to think about the child more deeply.

Here I have outlined a rationale for WMP with this cohort of children. I designed this study because I wanted to better understand the experience of WMP with this cohort of children through first-hand conversations with caregivers and professionals. I was interested in exploring both caregivers’ and professionals’ experiences because I believed WMP could be a helpful approach for both groups. I hoped to understand if there were challenges presented by using the approach with these children because, although I believed it could be a helpful approach, I understood there were several

aspects of WMP that could pose challenges, for example, this cohort of children may engage in repetitive play that appears limited. I was interested in exploring whether WMP could make a contribution to the professional network because I noticed the value of illuminating the child's experience, through play, when working with this cohort of children.

Chapter One: Literature Review

1.1 Introduction

I took a systematic approach and created a narrative literature review. I identified key areas and structured the review accordingly:

- Section A – Mental Health Services and Support for Under-fives
- Section B – Watch Me Play!
- Section C – Young Children in Care
- Section D – Professional Networks

1.2 Strategy

I completed several systematic searches between February and June 2025, to develop a comprehensive picture of the relevant literature and research. Below is a table and a narrative to account for my systemic search results.

Search topic	**Databases**	**Search terms**	**Relevant returned results**
Watch Me Play!	Tavistock and Portman Trust Library (using EBSCO Host)	'Jenifer Wakelyn' as 'author' & 'Watch Me Play!' in 'abstract'	5
Emerging ND and children in care	APA PsycINFO; APA PsycArticles; APA PsycBooks; APA PsycExtra; Psychology and Behavioural	'Young children' & 'emerging ND' as 'subject' & 'children in care' no limiters	4

	Sciences Collection; PEP Archive; Education Source; ERIC; SocINDEX with Full Text; CINAHL		
Occurrence of ND in children in care	As above	'Young child' & 'children in care' (extra terms for children in care to account for adopted children) as 'subject' and 'emerging ND' in 'abstract'	6
Child-led play with children in care with emerging ND	As above	'Play' & 'children in care' 'Play' & 'emerging ND'	3
Young children facing transitions	As above	'Young child' & 'children in care' as 'subject' (including terms for 'adopted child') & terms for 'transitions' within 'abstract'	2

In relation to WMP, I searched the Tavistock and Portman Trust Library (using EBSCO Host) online database collection, initially, with no limiters for 'Jenifer Wakelyn' as 'author' and returned 29 results. Several were repeated and some not relevant – I retained 5 (Appendix B). Next, I searched 'Watch Me Play!' in 'abstract' and found no additional results. Through communication with my research supervisor, Jenifer

Wakelyn, I discovered other WMP research (some not yet published) which is included in this review.

In relation to emerging ND and young children in care, I carried out another search in databases: APA PsycINFO, APA PsycArticles, APA PsycBooks, APA PsycExtra, Psychology and Behavioural Sciences Collection, PEP Archive, Education Source, ERIC, SocINDEX with Full Text, and CINAHL. These databases contain peer-reviewed literature and empirical studies in mental health, psychology, psychoanalysis, education, social care, and allied health. I identified 3 concepts – 'young children', 'emerging ND', 'children in care' and completed 3 advanced searches using related search terms for each concept, combined with Boolean operator 'OR'. I specified terms relating to 'young child' and 'emerging ND' must be 'subject', and no limiters for 'children in care'. I combined searches with Boolean operator 'AND' (Appendix C) returning 9 results of which 4 were relevant.

I was interested in finding research about the occurrence of ND in young children in care. I repeated the search with 'young child' and 'children in care' as 'subject' and 'emerging ND' in 'abstract'. I included extra terms for 'children in care', to account for adopted children. This search returned 15 results. I discarded those related to types of ND other than autism leaving 6 relevant results.

I wanted to better understand child-led play with children in care and children with emerging ND. I completed another search including further search terms for 'play' and combined these initially with 'children in care', and then with 'emerging ND' (Appendix C) returning 3 relevant results.

Thinking about young children facing transitions, I completed a further search using terms for 'young child' and 'children in care' as 'subject' (including terms for 'adopted

child') and terms for 'transitions' within 'abstract' (Appendix C) returning 2 relevant results.

In addition, I identified literature through conversations with colleagues, my research supervisor, and through 'snowballing' – identifying texts through relevant reference lists.

1.3 Table of Search Terms

Young Children	**Emerging Neurodivergent Development**	**Child in Care**	**Adopted Children**	**Play**	**Transitions**
Child*	Neurodiver*	"Looked after child"	Adoptive	"Child-led play"	"Placement move"
Pre-school	Autis*	"Cared for chid"	Adoptee	"Child-initiated play"	"Moving care"
Preschool	ASC	"Local authority care"	Adopted	"Free play"	"Placement breakdown"
"Early years"	Neurodevelopment*			"Non-directive play"	
Infan*				"Unstructured play"	

1.4 Section A – Mental Health Services and Support for Under-fives

This section addresses mental health provision for children in care, under five, with emerging ND and their caregivers at a national and local level.

1.4.1 Parent-Infant Mental Health Services and Child and Adolescent Mental Health Services

In recent decades, our understanding of infant mental health has developed exponentially with discoveries from child development research, psychoanalysis, attachment theory and neuroscience. It is widely agreed that the first two years of an infant's life are fundamental in shaping their development, and emotional and relational world (Leadsom et al., 2021; O'Meara et al., 2022; The Royal Foundation Centre for Early Childhood, 2021).

Nonetheless, investment in PIMHS has been lacking. There has been a strengthened movement of campaigning, led by the Association for Infant Mental Health (AIMH-UK) and the Parent Infant Foundation (PIF). Both organisations support professional development; campaign and lobby government; and raise awareness of infant mental health and early relationships.

PIMHS, as stated by PIF, are:

> Multidisciplinary teams with expertise in supporting and strengthening the important relationships between babies and their parents or carers.
>
> (PIF, 2025)

In the UK there is significant disparity in mental health provision for infants and young children; many areas have no PIMHS. In a review of provision, PIF found that interventions and services delivered by PIMHS to promote infant mental health are not widely available: "current provision is estimated to be just one tenth of total estimated need" (2024, p. 2).

PIMHS work closely with CAMHS to meet the mental health needs of young children and caregivers. A report detailing the history and development of CAMHS, recognised children and families:

> ... tend to present with troubling predicaments, not neat diagnoses. The multi-factorial nature of aetiology and the presence of co-morbid problems means there is still too little evidence about how to deal with the real-world dilemmas of many of our clients.
>
> (Cottrell & Kraam, 2005, p. 115)

This complexity is compounded for young children in care who may have moved between caregivers, so that their early experiences may not be understood or held in mind by any adults. Despite facing high levels of adversity, infants and young children in care are rarely referred to mental health services (Wakelyn, 2019c), in part because their needs cannot be described within diagnosable mental health terms. Wakelyn (2019c) recognises that the development of disadvantaged infants may be further compromised by difficult early relational experiences combined with prenatal risk factors, repeated losses and disruptions to early caregiving relationships. It is not unusual for mental health, emotional and relational needs to be minimised or overlooked; many children in care do not receive appropriate and timely support.

1.4.2 Early intervention

Several reports highlight the importance of early intervention. Evangelou and colleagues (2007) advise that disadvantage is intergenerational, established early and has cumulative effects (HM Treasury, 2003). Social exclusion and disadvantage occur within the structures of society as well as becoming embodied within the individual

psyche (HM Treasury, 2003), therefore effective early intervention needs to tackle both aspects. To have the most influence on parenting, interventions need to focus on younger children, and work with caregivers to increase ‘protective factors’ associated with resilience (Evangelou et al., 2007).

The ‘Best Start for Life: A Vision for the 1,001 Critical Days – The Early Years Healthy Development Review Report’ (Leadsom et al., 2021) brings together evidence to demonstrate that the first 1001 days, from conception to two years, is the foundation for later development. The report argues that families need access to comprehensive and seamless support provided by services that work together, are well-functioning, coordinated and multidisciplinary.

The Royal Foundation Centre for Early Childhood (RFCEC) report: ‘Big Change Starts Small’ (2021) recommends raising awareness of the extraordinary potential for change and development in the early years. The report emphasises that healthy development requires, and takes place within, nurturing relationships, environments and experiences. It notes that caregivers benefit from access to family-friendly support within non-judgmental environments that can encourage help-seeking and ensure early childhood is prioritised. When caregivers feel able to make use of helping relationships, the parent-infant or parent-child relationship is likely to benefit and strengthen.

A UNICEF ‘Early Moments Matter’ (O’Meara et al., 2022) report states the importance of early intervention; it also points out geographical disparity in the provision of services. The report shares an aim to ensure equal access to services for all babies and toddlers in the UK and asserts that services across education, health and care have a part to play in identifying need and providing timely support.

> Ensuring the right support is in place in the earliest moments of children's lives, including during pregnancy, is an effective way of improving outcomes for all children, transforming lives for those most at risk and closing the gaps between children furthest behind.
>
> (National Scientific Council on the Developing Child, 2020; O'Meara et al., 2022, p. 15)

This report reinforces the importance of the early years; with significant opportunities for growth and development through forming strong and positive relationships. Nonetheless, this is a time of unique vulnerability and dependence, meaning that the youngest members of society are at greatest risk of adversity which could have lifelong consequences. Many caregivers recognise this vulnerability, worrying about their young child's mental health and development. The 'Early Moments Matter' report finds that – 42% of parents in England with children 0–4 years have worried about their child's social or emotional wellbeing or behaviour (O'Meara et al., 2022). In an NSPCC survey, 75% of parents of under-fives described worrying about their child's mental health and 67% worried about their child's development (NSPCC, 2024).

Early intervention is even more important for young children who have experienced adversity and have emerging ND. A recent NHS report states that evidence-based early intervention is recommended as soon as possible after developmental differences indicative of autism are identified (Green et al., 2022). A report by the Early Intervention Foundation in collaboration with What Works for Children's Social Care (Casebourne, 2018) explains that early intervention that focuses on social and emotional development reduces the incidences of mental health problems for children and families who have experienced early adversity.

1.4.3 Table of approaches for young children in care with emerging ND – similarities to and difference from Watch Me Play!

Approach	Number of Studies	Core Aspects	Similarities to Watch Me Play!	Differences from Watch Me Play!
Solihull		• Training for parents and practitioners • Derived from psychoanalytic thinking, child development research and social learning theory • Draws on principles of containment, reciprocity and behaviour management • Promotes and enhances sensitive, attuned relationships • Promotes reflective function • Promotes child and parent emotional regulation	• Psychoanalytically informed • Promotes reflective function	• Solihull is a training programme offering psychoeducation to parents/carers and practitioners • Solihull is either offered online or as a group intervention for parents/carers • Solihull provides an online training programme for professionals • WMP has a narrow focus on enhancing child-led play
Developmental Dyadic Psychotherapy (DDP)	16	• Attachment focused therapy • Often used with foster carers and adoptive parents • Promotes a sense of relational security • Promotes reflective function and mentalizing • Encourages a playfulness and curiosity	• Designed for work with foster carers • Promotes reflective function • Encourages playfulness	• DDP is therapy • DDP focuses on enhancing child and caregiver attachment whereas WMP has a narrow focus on enhancing child-led play between caregiver and child • DDP is usually suitable for children between 8 – 18 years whereas WMP focuses on younger children 0 – 8 years
Video Interaction		• Parent-infant therapy that uses video	• Promotes attunement	• VIG is therapy

Guidance (VIG)		• Promotes attunement • Enhance sensitivity in the parent-infant relationship	• Enhances parental sensitivity	• VIG creates opportunities to reflect on play and interactions through watching video after the interaction whereas WMP encourages in the moment 'in vivo' comments followed by an opportunity to reflect together after the play • Suitable for infants and young children with a wider age range than WMP however most often used with parents/carers and infants under 2
Watch Wait and Wonder	2	• Parent-infant therapy • Suitable for infants between 6 – 30 months • Focus on infant's free play to improve parent-infant relationships • Enhances maternal sensitivity and responsiveness • Supports bonding and attachment • Reduces parental stress • Improves infant emotional regulation	• Focus on infant-led play • Improves parent-infant relationships • Enhances parental sensitivity	• WWW is therapy • Suitable for infants between 6-30 months whereas WMP suitable for children up to 8 years (often older when there is ND or learning disability) • Focuses on improving parent-infant relationship and enhancing sensitivity and responsiveness whereas WMP has a narrower focus on enhancing child-led play between caregiver and child
Intensive Interaction	65	• Speech and language therapy approach • Suitable for children, young people and adults with	• Encourages child-led play and interactions	• II is a speech and language therapy approach • Suitable for children, young people and

		developmental delay and/or autism • Encourages caregivers to follow their child's lead in play and interactions • Facilitates shared attention and enjoyment	• Facilitates shared attention	adults with developmental delay and/or autism • II is about supporting interaction whereas WMP has a narrow focus on enhancing child-led play between caregiver and child
Peers Early Education Partnership (PEEP)		• Family-based early education intervention • For school-aged children from disadvantaged backgrounds • Increases literacy and other learning outcomes • Focus on child-led play • Encourages joint play sessions between parents and children	• Focus on child-led play • Encourages joint play between parents and children	• PEEP is an education intervention • Suitable for school-aged children • Focus on increasing literacy whereas WMP has a narrow focus on enhancing child-led play between caregiver and child
Portage		• Home visiting service • Supporting young children with special educational needs and disability (SEND) • Focus on child-led play • Recognises the benefits of closely observing the child's free play	• Recognises the value of observation and child-led play	• Portage is a home visiting service approach • Designed only for children with SEND • Designed for pre-school children • Portage has three core elements child-led play, structured teaching and family focus whereas WMP has a narrow focus on enhancing child-led play between caregiver and child

1.4.4 Approaches for young children in care with emerging ND

A range of approaches have been developed to meet the needs of this cohort of children. They include the Solihull approach (Douglas, 2004), and Developmental Dyadic Psychotherapy (DDP) (Hughes, 2006) which informs the Foundations for Attachments Training (Golding, 2018) and is informed by a Playful, Accepting, Curious, and Empathic (PACE) therapeutic approach.

The Solihull approach is an evidence-based approach to training for practitioners and parents that draws on the principles of containment, reciprocity and behaviour management and is derived from psychoanalytic thinking, child development research and social learning theory. In-person parenting groups and online parenting programmes, support parents and practitioners to understand the importance of, and develop, attuned and sensitive relationships that can promote emotional health and wellbeing, and reflective thinking, so child development can be more deeply understood. Links between behaviour and emotions, and parental and child emotional regulation, are emphasised. Douglas and Johnson (2019) report a statistically significant reduction in parental anxiety and stress, reduction in conflict, and increase in closeness between parent and child following a 10-week in-person Solihull group.

DDP is “an attachment-focused therapy” which is “frequently used with adoptive and foster families” (Wingfield & Gurney-Smith, 2019, p. 661) with a growing evidence base (16 published studies). Studies focus on DDP with children in foster care or adopted children, and recognise that this population, who have likely experienced neglect and abuse, often present with difficulties stemming from the impact of trauma upon development (Golding, 2019). None focus specifically on DDP when used with children who have emerging ND, nonetheless these studies make reference to the

prevalence of neurodevelopmental difficulties for children in care and adopted children. Several studies describe these children struggling with a sense of safety and stability in relationships. They describe how children's felt sense of security is influenced in many ways, including how children's transitions between caregivers have been supported, how children have experienced parenting (pre and post adoption) and the degree to which children experience neurodevelopmental difficulties (Staines et al., 2019; Golding, 2019; Wingfield & Gurney-Smith, 2019). These studies highlight how DDP aims to increase parents' capacity to be reflective and mentalize and encourage a PACE approach in their interactions with their children. Through doing this these studies find that children's attachment security increases (Golding, 2019).

Many approaches with young children recognise the value of individual attention and encourage caregivers to develop this, for example: Video Interaction Guidance (VIG) (Kennedy, 2011) and Watch, Wait and Wonder (WWW) (Lojkasek, 2025). VIG uses video to support caregivers to notice moments of attunement to enhance sensitivity in the parent-infant relationship. WWW is a psychotherapeutic approach that supports caregivers to focus on their infant's free play to improve parent-infant relationships and enhance maternal sensitivity and responsiveness. WWW is suitable for infants (aged between six and thirty months). A small evidence base (1 RCT and a follow up study) concludes that WWW supports bonding and attachment, reduces parental stress, enhances parental sensitivity, and improves infant emotional regulation, when offered over eight to eighteen weekly sessions (Cohen et al., 2002; Cohen et al., 1999; Lojkasek, 2025).

Another approach that encourages caregivers to follow their child's lead in play and interactions is Intensive Interaction (II) (Intensive Interaction Institute, 2015); a speech and language approach that involves 'total communication' and social inclusion for

children, young people and adults with significant developmental delay and/or autism. With children, the II partner spends time following the child's lead and mirroring their movements, sounds and facial expressions. The aim is to facilitate shared attention and enjoyment. II takes place in a safe environment and is repeated to build trust and familiarity which supports relationship building, interaction and communication. Research (65 published studies) reports a range of improved relational and communication outcomes (Hutchinson & Bodicoat, 2015).

Children engage in play not simply for learning; although learning and development occur, play in itself is a fundamental motivator and is inherently pleasurable and meaningful (Music, 2016; Panksepp, 2007). Being together during play can be compromised for young children and caregivers when there are difficulties, such as, disruption to early caregiving relationships and/or emerging ND. In a study of mothers who had used II with their child with intellectual disability and/or autism, one parent remembers asking her child's Health Visitor: "please help me to play with my child" (Berridge & Hutchinson, 2022, p. 398).

Interventions for young children in care and/or with emerging ND, such as II and the Solihull approach, recognise the importance of encouraging child-led play through commenting on the child's play or describing it. The Peers Early Education Partnership (PEEP) (Evangelou et al., 2007), a family-based early education intervention aimed to increase literacy and other learning outcomes for children from disadvantaged backgrounds, has a similar focus on child-led play through encouraging joint play sessions between parents and children. Portage, a home visiting service supporting young children with special educational needs and disability, include child-led play as a core element of the model, recognising the benefits of closely observing the child's

free play to understand their development, interests, strengths and difficulties (National Portage Association, 2024).

1.5 Section B – Watch Me Play!

This section provides a comprehensive review of literature on WMP, exploring the development of the approach, its theoretical underpinnings, distinctive aspects, and the factors that appear to influence change, with specific consideration of elements relevant for this cohort.

1.5.1 Watch Me Play! Literature

Lead Author	Date	Publication	Title	Case examples
Wakelyn, J.	2011	Article in Journal of Child Psychotherapy	Therapeutic observation of an infant in foster care	Rahan
Wakelyn, J.	2012	Article in Journal of Infant Observation	Observation as a therapeutic intervention for infants and young children in care	Rahan
Wakelyn, J. IN: Rustin, M.	2019	Book chapter	Clinical research and practice with babies and young children	Rahan, Angus, Kiara & Kyeshawn, Molly, Ameera, George
Wakelyn, J. IN: Bunston, W and Jones, S.	2019	Book chapter	Developing and intervention for infants and young children in care: Watch Me Play!	Alex & Julia, Aisha, Rani, Samuel
Wakelyn, J.	2019	Article in Journal of Infant Observation	Observation and attention in professional	Rahan, Ania, Henry

			network meetings for children in care	
Wakelyn, J.	2019	Book	Therapeutic approaches for young children in care: observation and attention	Rahan, Ania, Danny, Kyle & Bella, Noemi, Miguel, Samuel, Amy
Randell, L	2024	Research protocol in Pilot and Feasibility Studies	Watch Me Play!: protocol for a feasibility study of a remotely delivered intervention to promote mental health resilience for children (ages 0-8) across UK early years and children's services	N/a
Hunter, C.	2024	Unpublished doctoral thesis	How do parents experience Watch Me Play! alongside the multi-disciplinary assessment of their under-five year old's social communication difficulties? An interpretative phenomenological analysis	N/a
Wakelyn, J.	2025	Article in Journal of Infant Observation	Psychoanalytic aspects of the Watch Me Play! approach: the psychic energy of attention	Molly
Koenig, A.	In prepa ration	Single group feasibility study submitted for publication	A feasibility study of Watch Me Play! for parents of young children with a developmental delay	N/a

1.5.2 Origins of WMP

Jenifer Wakelyn, a Child and Adolescent Psychotherapist, developed WMP whilst working with children in foster care, their caregivers, and professional networks. Wakelyn has written (2011, 2012, 2019a, 2019b, 2019c, 2019d, 2025) on the development of the approach from its origins in infant observation and has shown a keen interest in the importance of child-led play and the vital nature of attention for children's growth and development. There is wider interest in researching WMP through feasibility studies and doctoral research.

WMP is fundamentally grounded in understanding the value of an observational stance. WMP practitioners embody an observational position and encourage this in caregivers. This supports children to experience emotional containment, attention and interest from their caregiver and creates space for children to show what they think and feel, through play. For children, regularly experiencing their caregivers' curiosity about their play promotes their capacity to play and their self-expression through play.

This observational approach is informed by psychoanalytic therapeutic training, where infant observation is a method of learning about child development, in the context of their early relationships and ordinary 'good enough' family life (Bick, 1964; Winnicott, 1953). Wakelyn developed WMP from her experience of therapeutic observation with an infant in foster care. Therapeutic observation differs from infant observation. It is a clinical intervention, undertaken by a qualified clinician, who can proactively meet specific clinical needs. Wakelyn described how an observational stance can be especially helpful for young children in care: the observer can provide containment for the child-caregiver dyad, can encourage attuned and sensitive interactions, and can modulate experiences of separation by noticing and giving voice to the child's feelings

(Rhode et al., 2012; Wakelyn, 2011). Child development research, neuroscience and psychoanalysis tell us that infants develop a sense of self from seeing and understanding themselves as reflected in the other (Bowlby, 1969; Fonagy, 2002; Siegel, 1999; Winnicott, 1971). Young children in care have significant challenges in developing a coherent sense of self. For these children, being seen with attuned curiosity can be a powerful experience that can support their development and emerging sense of self.

'Therapeutic observation of an infant in foster care' shares thoughtful and evocative presentations of observations with Rahan, an infant in foster care and his caregiver Nadira (Wakelyn, 2011). The paper contrasts experiences of connectedness, with experiences of 'trauma-driven' disorganisation, within organisations involved in care planning for young children in care. Wakelyn suggests that psychoanalytically informed infant observation contributes to caregivers and professionals becoming more in touch with the infant's emotional reality, especially during transitions, and can provide a voice for the child during care planning. The paper recognises that professionals and caregivers are under enormous pressure, navigating overwhelming feelings of loss and rupture, stirred up by the infant's experiences.

In 'Observation as a therapeutic intervention for infants and young children in care' (Wakelyn, 2012) extends these ideas to describe clinical applications of therapeutic observation in clinical work with children in care. She comments that children in care are at much higher risk of mental health difficulties in childhood and later life, and their capacity to form secure attachments is profoundly compromised (Lauritsen, 1993; Wakelyn, 2012). This paper explores the complex tasks of foster carers who bridge personal and professional worlds in caring for vulnerable, often traumatised young children. The impact of secondary trauma, and the complex nature of their role, can

affect foster carers' sense of authority in speaking up for the emotional and psychological needs of the child. Findings suggest that therapeutic observation can be used flexibly to meet the needs of children in care and their caregivers. At times of transition, it can provide a:

> …degree of background continuity and mindful containment for infants and young children facing inevitable disruptions in external and internal aspects of their care.
>
> (Wakelyn, 2012, p. 63)

Therapeutic observation has proved effective as an early intervention for young children with emerging ND (Houzel, 1999; Rhode, 2007; 2012). Papers by Houzel (1999) and Rhode (2007; 2012) suggest that a therapeutic observational approach offers emotional containment to caregivers who can share their worries about their child's development. In being listened to, caregivers have opportunities to reflect on their feelings towards their child and their developmental difficulties. In so doing, worries about their child's developmental difficulties and their capacity to parent their child, can become thinkable. Therapeutic observation can support caregivers of children with developmental delay and ND, to break free of a sense of inadequacy and failure and develop a sense of agency and confidence that they can get to know their child, understand them and make a difference to them.

Four publications in 2019: two book chapters, one journal article and a book each build on the earlier papers, drawing from the author's experience of applied therapeutic observation and explaining how this led to clinical research, service development, and the creation of WMP. In 'Clinical research and practice with babies and young children' (Wakelyn, 2019a) outlines findings from Wakelyn's doctoral project. She discusses the

disorganising impact of dynamics of trauma on professional networks for young children in care and on the caregiver-infant dyad and describes the mitigating influence of child-led play against dynamics of rupture and discontinuity. She continues to lay out the core principles of WMP, explaining that the approach draws upon:

> ... core principles that have been common to evidence-based approaches and clinical practice with distressed and troubled young children for decades and are supported by child development research from many perspectives.
>
> (Wakelyn, 2019a, p. 300)

Observational vignettes from Wakelyn's clinical work are shared to demonstrate the process, and impact, of WMP with a range of families. A little boy, Kyeshawn, fostered aged three with his younger sister Kiara, was supported by WMP. This approach was new to his caregiver, who found his repetitive play challenging. After three months, clear developments had taken place: he played more freely, he displayed more agency – by making his own choices in play and trying out new toys – and it became enjoyable for Kyeshawn and his caregiver to be together. Alongside these developments in play, a reduction was seen in his symptoms – his feeding difficulties had resolved, he could sleep separately from his sister, and he became less hyper-vigilant. Molly, a baby in foster care, was difficult to soothe; she was born addicted to heroin. Molly's caregiver was encouraged to turn off the television and create a quiet space for play. This supported Molly and her caregiver to experience more attuned interactions during WMP. Once her caregiver could attune to her interactions she was more able to recognise and respond to Molly's signals of distress, and long periods of inconsolable crying reduced. Ameera was a toddler in foster care. WMP sessions developed more warmth between Ameera and her caregiver following a painful rift felt between them.

Wakelyn (2019a) suggests that the experience of play and mutual enjoyment allowed closeness and attachment to grow. George's foster carer was supported by WMP telephone sessions. She began to hold back and focused on being curious about his play and George, who had been shy and restrained, was able to play and express himself more freely.

Wakelyn (2019a) finds that the observational stance in WMP has value when supporting young children in care and their professional networks. She comments that the protective nature of close attention from a caregiver, can be impaired or less available to children in care. When given undivided attention, the child can feel held in mind and the caregiver can develop a deeper and more meaningful sense of their child's interests, dislikes, strengths and difficulties. This can create a more coherent picture of the child's emotional world in the mind of the caregiver, and the professional network, which can mitigate against the fragmentation caused by the impact of trauma.

A second chapter, 'Developing an intervention for infants and young children' (Wakelyn, 2019b) outlines the principles of WMP and the theory and rationale behind it. By offering warm and genuine interest, and attention to a child's free play, caregivers can become more attuned, experience mutual delight, create feelings of safety and enhance opportunities for exploration and playfulness. There is a substantial body of evidence that demonstrates children who have experienced disruption to their caregiving relationships and abuse and neglect from caregivers, are likely to have lacked attuned care and find it more difficult to relate, communicate and learn in later childhood (Schore, 2001). The author comments that child-led play is not often prioritised in foster care training. Instead, there is a focus on behaviour management and maintaining routines, which however important, risks missing fundamental opportunities to facilitate children's play and provide individual attention and moments

of intimacy that are vital for development, relationships and mental health (Hardy et al., 2015; Meakings & Selwyn, 2016).

‘Observation and attention in professional network meetings for children in care’ was published in the Journal of Infant Observation (Wakelyn, 2019c). The author highlights the severity of the adversity faced by young children in care and the profound impact this may have on their attachment style, relationships and development. The article sets out the rationale for therapeutic observational approaches with this cohort, creating opportunities to stay in touch with the child’s emotional experience and bring it to life in the minds of caregivers and professionals. The importance of maintaining communication with professional networks is highlighted to enhance effectiveness and influence change. Informed by psychoanalytic theory, Wakelyn explains that such observational approaches, which keep alive the emotional experience of the young child for the professional network, enabled coming together and reflective thinking. Bion (1962a) called this containment, alpha function and reverie.

Wakelyn discusses two different aspects of attention, passive and active, that contribute to the observational stance. Drawing upon psychoanalytic theory (Freud, 1909) which described the function of attention as initially receptive – the observer attends to the child’s play and receives perceptions without judgment, questions or directing the child, and then more active – the observer can look for meaning.

Published in the same year, ‘Therapeutic approaches with babies and young children in care: observation and attention’ consolidates themes from these papers, detailing further aspects of WMP and theory that informs the approach (Wakelyn, 2019d).

In 2021-2023 a single-group feasibility study of WMP was undertaken (Koenig et al., submitted for publication). The study aimed to assess feasibility and accessibility of

WMP for parents of young children with developmental delay. Preliminary findings supported the hypothesis that WMP had potential as an intervention for young children with developmental delay and their caregivers, although more research was indicated. It was noted that some parents reported developments in their child's play they did not think were possible.

The protocol for another feasibility study of WMP was published in 2024 (Randell et al., 2024a). A report on the study is available online from the Foundations website (Randell, 2024b). This was a mixed methods study that explored the feasibility and acceptability of a future randomised controlled trial. Findings conclude that there was an appetite from services and families for WMP delivery and participation. The study recommends further feasibility trials before progression to a full-scale effectiveness trial.

A child psychotherapy doctoral project explored parents' experience of WMP alongside diagnostic assessment for under-fives with social communication difficulties, including possible autism (Hunter, 2024). Findings (from the four families who took part) indicated that caregivers of young children being assessed for social communication difficulties, experienced the WMP practitioner as pivotal to their experience of the intervention and the assessment. Caregivers reported feeling greater confidence in the WMP practitioner, perhaps due to a therapeutic relationship that developed and was felt to be more individual than the standard assessment procedure.

In 'Psychoanalytic aspects of the Watch Me Play! approach: the psychic energy of attention' (2025), Wakelyn locates WMP in its psychoanalytic foundations. The paper describes the development of WMP from 2011, with a focus on advocacy for the infant

or young child in care's emotional experiences and needs, to a more widely used approach that can benefit parent-child relationships and interactions, children's communication and behaviour, and parent's understanding of their child and their needs. Three key and essentially psychoanalytic aspects of WMP are outlined – the transformative effects of undivided attention (Freud, 1909), the importance of spontaneous and potentially symbolic child-led play, and opportunities for surprise and discovery.

1.5.3 Distinctive aspects of WMP

WMP draws on principles that are common to other approaches used with young children and their caregivers, nonetheless, some aspects of the approach are distinctive. WMP has similarities with WWW in that it encourages caregivers to watch their child's play and reflect with a clinician afterwards, however, unlike WWW, WMP is not a form of parent-infant therapy. Instead, WMP is aimed at increasing opportunities for child-led play between children and their caregivers, in the understanding that play is vital for children's learning and development, social and emotional wellbeing and relationships (Meins et al., 2013; Music, 2016; Smith, 2005).

Parenting courses and groups, such as the Solihull approach raise awareness of the importance of child-led play and share theory from child development research. WMP is different because WMP practitioners come alongside individual caregivers, to learn together about how to encourage child-led play, which for some caregivers can feel very new and very challenging.

WMP shares core elements (infant observation, individual attuned parental attention, child-led play) with several programmes for young children and caregivers. PEEP

suggests that infants learn about talking, listening and communicating when their caregiver can watch them closely, attend to their gestures, movements and vocalisations with interest, follow their lead, and talk to them about what they are doing during playful interactions (Evangelou et al., 2007). WMP has a similar focus on close attention and contingent response which supports caregivers to become more attuned to their infant or young child, increases opportunities for child-led play, shared enjoyment and the possibility for spontaneity and discovery. This enhances the relationship and provides important developmental experiences.

Supporting child-led play for children in care can be complicated. Foster carer training may tend to put an emphasis on physical care and behaviour management. Foster carers are often encouraged to take children to stay and play groups and to nurseries, but less importance may be given to individual attention, interaction and play with caregivers at home (Wakelyn, 2019a). This may be, in part, because foster carers and social workers might experience free play of children in care as disturbing: children who have experienced trauma, and children with emerging ND, can play in ways that confuse, distress, or frustrate others. Understandably this can result in caregivers being more directive or avoiding play altogether. Nonetheless, for children in care and children with emerging ND, child-led play, if encouraged and facilitated, can provide a means of communication, interaction and connection with caregivers. This suggests that support provided by the company of a WMP practitioner, may be needed for caregivers to manage the experience of being with their child as they play.

In WMP, after the play sessions, the caregiver talks with the WMP practitioner, or another adult, about the experience of watching their child's play. This can be a powerful experience for the child to witness (their caregiver talking about them and holding them in mind), just as it can be a powerful experience for the caregiver to

encounter a practitioner who is interested in them and their child's play. This kind of talking allows for emotional experiences to be known about, to come to life and to be survived, offering containment (Bion, 1962b), promoting mentalization (Fonagy, 2002) and a capacity to reflect on their own experience and their child's experience (Meins et al., 2013). This supports caregivers to get to know their child more deeply and the child to feel seen and witnessed.

The WMP approach is flexible and can meet individual needs of children and caregivers. For caregivers who find playing with their child difficult, a tailored approach, such as sessions just for the caregiver or telephone support between sessions, can be provided to explore challenges and to look for micro-moments of progress or connection. These opportunities for reflection provide caregivers with emotional containment (Bion, 1962b) and can create a space to think about their own experiences of play as a child and how this may be colouring their experiences of play with their child (Fraiberg et al., 1983). Enhancing reflective function and mentalization – the capacity to think about one's mind and other's minds – in this way allows the sessions with the child and caregiver together, to be focused on increasing opportunities for child-led play.

Unlike many other approaches, WMP has a narrow focus on increasing opportunities for child-led play and helping caregivers and young children to overcome barriers to child-led play. WMP provides clear guidance – finding a quiet space without distractions and a few simple toys, turning off the television and putting away mobile phones for the duration. This sounds relatively simple but can be underestimated in the modern world and can be challenging for caregivers.

1.5.4 Factors that could influence change

Some aspects of WMP appear to be catalysts for change. Fundamentally WMP is an approach that aims to improve caregiver-child relationships through promoting child-led play and attuned attention. There is compelling evidence that supporting relationships between caregivers and young children is of primary importance. The PEEP evaluation found that supporting quality caregiver-child relationships is an effective early intervention strategy to promote learning (Evangelou et al., 2007). It has been found that interventions that support caregiver-child relationships early can improve infant attachment security and emotional quality within the relationship (Barlow et al., 2016).

WMP takes a non-directive approach to children's play, yet a directive approach to caregivers, guiding them to be with their child in a different way. This is done through in-the-moment, immediate feedback during caregiver-child interactions – 'in vivo' comments. A study by Bergsund and colleagues (2023) explored the feasibility of transporting an Attachment and Bio-behavioural Catch-up programme (ABC) to another country and found in vivo coaching was most effective in shaping parental behaviour (Barnett et al., 2014; Barnett et al., 2017; Heymann et al., 2022). Shanley and Niec (2010) proposed this method of providing guidance as one of the active ingredients or catalysts for change in evidence-based caregiver-child programmes.

Meins and colleagues (2013) explored the relationship between caregiver mind-mindedness and symbolic pretend play in children. Mind-mindedness was recognised as caregivers' capacity to see their infant as separate from them and with their own mind. They reported a positive correlation between caregivers' tendency to talk to their

child in a mind-minded way and an increase in children's symbolic play and development of theory of mind.

Wakelyn (2025), based on her own and other WMP practitioners' experience, found that in WMP often something happened as a surprise or something new developed. This element of discovery is indicative of development and may relate to a sense of agency becoming established for the child, who feels safe enough to try something new (Ye et al., 2024) and the caregiver who, in the understanding that the WMP practitioner will be interested, can trust their knowledge of their child and notice their new achievements. Wakelyn found this experience of discovery and seeing something new led to more confidence in caregivers and became a motivating factor for carrying on with WMP, as it increased enjoyment for caregiver and child.

1.6 Section C – Young Children in Care

This section collates literature on emerging ND and the relationship between, and co-occurrence of, care experience and ND, including literature on young children in care facing transitions.

1.6.1 Early deprivation and neurodivergence

Child development researchers (Bowlby, 1969; Fonagy, 2002; Meins et al., 2013; Music, 2016, 2024; Siegel, 1999; Winnicott, 1971) and policymakers (Leadsom et al., 2021; RFCEC, 2021; UNICEF & The University of Cambridge's Centre for Research on Play in Education Development and Learning (PEDAL), 2023) have contributed to an understanding of what young children need to grow and develop and recognised

the influence of early deprivation on children's development (Debnath et al., 2020; Fraiberg et al., 1983; Green et al., 2016; Henry, 1974; Schore, 2001). In recent years there has been interest in exploring the influence of early deprivation, disruption to caregiving relationships, neglect and abuse, on neurodevelopment, including symptoms of autism.

Understanding has been drawn from longitudinal research on children raised in Romanian orphanages, who experienced extreme emotional and relational deprivation, and have been found to display 'quasi-autistic' features (Flackhill et al., 2017; Rutter et al., 2001). Much higher rates of ND (specifically features of autism) have been found in cared-for children, who are more likely to have experienced early deprivation and adversity. One study reports that 11% of adopted children presented with neurodevelopmental features associated with autism and a further 18.5% presented with partial features of autism, in comparison to 1-2% in the typical population (Green et al., 2016; Parsons et al., 2019). In someways this creates more questions than it answers – is it that early deprivation, abuse, trauma and disruption to caregiving relationships is a risk factor for autism? Is autism over-diagnosed in the absence of more nuanced clinical understandings of these developmental and relational presentations? Or could it be that young children with emerging ND are more vulnerable to relational misattunements that put them at higher risk of early relational trauma? It is likely that all aspects are relevant and a rich area for further research.

These findings have led to calls for guidance to help practitioners and clinicians better understand, and differentiate between, autistic features and attachment difficulties in this vulnerable group; so that, the complex emotional, relational, behavioural and learning needs of children with possible autism and attachment difficulties can be met with appropriate approaches (Flackhill et al., 2017). Researchers have designed 'The

Coventry Grid' to contribute to a deeper understanding of the differences between trauma and autism presentations and an interview that can support clinicians to tease apart these differences (Moran, 2010; Flackhill et al. 2017). Kanner (1995) recognised that in the original group of children whom he categorised as autistic, their development and outcomes varied hugely, and there was no single intervention or approach that helped (Rhode & Grayson, 2018).

Current researchers have outlined an integrated model of autism which brings together biological influences, such as brain structure and function and hormonal levels, with social and emotional influences, that combine to establish and perpetuate autism (Rhode & Grayson, 2018; Singletary, 2015). For example, an infant's atypical eye contact may impact on interactions with their caregiver and affect the developing relationship even from the earliest days, potentially leading to repeated mis-attunements that can result in further developmental and relational deficits (Martin, 2020). Rhode and Grayson (2018) comment on a study by Wan and colleagues (2013) which found that caregivers of infants at high risk of developing autism were more directive in interactions with their child and less sensitively responsive. It was hypothesised that this could be an adaptation by caregivers in response to atypical interactions with their child, or to their child's lower levels of vitality and engagement. Another study by Green and colleagues (2017) finds that following a caregiver-infant video-feedback intervention, caregivers were less directive in interactions with their child and more attentive to their child initiating interactions.

1.6.2 Young children in care facing transitions

High-quality foster care placements and a stable caregiving environment have been found to be essential for brain development in previously institutionalised children (Debnath et al., 2020). It could be inferred that these are equally important for development and healing for children who have experienced abuse, neglect and disruption in relationships, typical of young children in care.

In addition to early adversity, children in care face transitions between caregivers. Transitions can perpetuate painful feelings of loss and abandonment and stir up feelings related to primary losses. These experiences constitute significant relational trauma (Browning, 2015; Lanyado & Caldwell, 2002; Wakelyn, 2011). Researchers found that placement disruptions for children who had experienced institutionalised caregiving, adversely affected behavioural, social and emotional development and increased externalising and internalising behaviour problems (Debnath et al., 2020; Lewis et al., 2007; Rubin et al., 2008). The authors propose that these findings contribute to a deeper understanding of the benefits of high-quality foster care placements and stability for all children who have experienced early relational trauma and disruption in their caregiving relationships (Debnath et al., 2020).

A qualitative study exploring adoptive parents' experiences of transition between foster care and adoption found that children’s feelings of loss were not always recognised and, at times, were defended against with unhelpful language, such as, a ‘smooth’ transition (Lewis, 2018). The author suggested considering longer transitions to give more time for children to grieve losses including the separation from their foster carers as well as unconscious links to earlier losses (Browning, 2015; Lanyado & Caldwell, 2002).

Similarly, Beek, Neil and Schofield (2021) and Boswell and Cudmore (2014) recognised that children's feelings of loss and separation can be overlooked during transitions, especially those that happen quickly. Beek, Neil and Schofield (2021) outline a model for supporting children to move from foster care into adoption, based on six core principles; focusing on the importance of building strong relationships and retaining some continuity in relationships between children and foster carers (Beek et al., 2021; Boswell & Cudmore, 2014). They suggest relationship building can be supported by opportunities for the child and adoptive parents to become familiar with each other through play and observation and this should happen prior to adoptive parents undertaking caregiving tasks. They describe how the child's needs and feelings should be responded to sensitively, be held in mind, and be central to plans and timescales. Likewise, Boswell and Cudmore (2014) conclude that transitions should be gradual and allow for some ongoing meaningful contact between children and foster carers (Beek et al., 2021), recognising transitions are emotionally significant, whether the child can express this or not.

Browning (2015) outlines the opportunities transitions can provide by offering an experience of a different kind of move, in which painful feelings can be recognised, processed and mourned. Like Lewis (2018), he suggests that transitions should be gradual to give time to process the experience and remain in touch with the painful emotions evoked by a move, and a supportive and functioning professional network is needed to enable this to happen.

1.7 Section D – Professional Networks

This section focuses on research and literature exploring the different ways professional networks function and the anxieties and defences that may be stirred up in organisations working with this cohort.

1.7.1 Needs of professional networks – how help and partnership is experienced

Professional networks are complex systems, especially those aimed at helping vulnerable young children. Robinson and Midgley (2024) described various challenges for professionals working within professional networks, supporting children in care and navigating children's services and CAMHS. They found many complexities around inhabiting different professional identities whilst working in professional networks; other authors recognise that different perspectives, priorities and aims can lead to tensions (Callaghan et al., 2004; Conway, 2009; Golding et al., 2010; Kelly et al., 2003). They advocate for strong working relationships between allied professionals which can be fostered through "mutual respect of professional roles and responsibilities" (Robinson & Midgley, 2024, p. 68).

A paper by Bevington and Dangerfield (2024) refers to the Adaptive Mentalization-Based Integrative Treatment (AMBIT) approach for increasing mentalization to support teams working with complex children and families who have little trust in help (Bevington et al., 2017). Bevington and Dangerfield find that, despite the desire to work collaboratively and effectively, when professionals are navigating high levels of risk and unpredictable disruptions, even the best-intentioned workers and teams will experience extensive and recurrent misalignments. This can make providing effective

help to children and caregivers challenging and overwhelming and can affect the way help offered to families is experienced by professionals. Wakelyn (2019c) finds that the observational approach in WMP has the potential to create professional curiosity and support professional networks to come together, with a focus on the child's experiences and needs.

1.7.2 Organisational anxieties and defences in work with vulnerable children

Anxieties, and the defences employed to protect against them, affect work groups and teams functioning. Institutions might develop defences to protect themselves and their members against pain and threat from various sources, including the nature of the work itself (Obholzer & Roberts, 2019). Menzies-Lyth (1960) recognised that health and caregiving organisations were particularly vulnerable to employing structural defences. These defences offered some short-term successes by relieving anxiety, however, once entrenched, they hindered personal growth and the provision of authentic and quality care.

Obholzer and Roberts (2019) describe some defences observed in organisations: 'projection and splitting' of unbearable and conflictual emotional states which can then be attributed to external sources; 'envy' of others' success, felt as threatening which can result in spoiling attacks; and 'projective processes' whereby professionals may feel emotional experiences belonging to the children and families, as their own, making them vulnerable to acting out. These complex emotional dynamics can lead to burnout, impacting on professionals' capacity to work together, to be reflective and to recognise their own emotional experience and needs and those of the children they are supporting.

These ways of organisational functioning may not only be a defence against, but a feature of, the intensity and painfulness of the work, and related to secondary trauma. Emanuel (2002) documented her experience of setting up a service for children in care. She recognised these complex tasks and coined the term ‘triple deprivation’. This refers to three levels of deprivation. The original trauma – abuse, neglect, loss and disruption to the early care, which deprived the child of ordinary, good enough parental care needed for growth and development. Compounded by the defences employed by children to manage the original trauma. These defences can become rigid and entrenched, meaning the child cannot make use of the help and support available to them. She recognised a similar impairment within professional networks where disturbed and disrupted attachment styles, seen in young children in care, take hold in professional teams and are acted out in various ways. It is not surprising that working in such contexts, social workers can feel frightened, desperate and overwhelmed.

1.7.3 Helping professional networks to function and think

Bion (1961) developed theories of group functioning, stating that groups are vulnerable to ways of working driven by unconscious emotional states that override the task of the group, he called this ‘basic assumption mode’. He recognised that well-functioning groups are able to focus on the task, maintain clear roles and cooperation, engage with reality and contain feelings – in doing so, they learn from experience (Bion, 1961, 1962b). He called this ‘working group mode’ and suggested this way of functioning can be supported by containment and reflective practice.

Similarly, more recent research confirms the importance of professionals having support to mentalize (Bevington & Dangerfield, 2024). Under emotionally demanding conditions mentalizing is more difficult and can become blocked. When this happens, professionals require help from others who can mentalize their experience to support them in beginning to mentalize again. Wakelyn (2019c) suggests that a focus on the experiences, interactions, and play of the individual child can support professionals to remain attentive to the child's emotional reality. In this way, WMP can help professional networks to come together, engage with and contain feelings, mentalize and develop reflective thinking.

1.8 Conclusion

In my review, I found literature confirming the value of quality early childhood experiences which lay the emotional, relational and behavioural foundations for future learning and development. Research recognises the importance of timely intervention, particularly for children who are increasingly vulnerable, and their caregivers. Despite this, I found evidence of disparities in the provision of services.

I found a range of interventions for this cohort which had some specific differences but shared similar child-focused principles to WMP and aimed to develop caregivers' mind-mindedness through containment and opportunities to reflect.

I encountered many studies relating to the co-occurrence of emerging ND and care experience, with a focus on links between trauma and neurodevelopmental presentations. I found a growing body of research about the importance of, and ways to support, transitions for children in care. I discovered a small yet growing body of WMP research which indicated a shared curiosity about the application of WMP with

young children with developmental delay and/or autism. I identified research and literature that recognised the challenges for professional networks working with vulnerable children and families. I found recent research around developing approaches to support this work by facilitating spaces to increase mentalizing in professional networks.

My review identified a number of gaps in the literature. I did not find any research exploring interventions to support this cohort through the medium of play and reflection on play. Many approaches aimed to encourage child-led play, though none specifically focused on supporting caregiver-child relationships through increasing child-led play for this cohort. Professionals, caregivers and researchers seemed to agree that child-led play with children with emerging ND is more challenging, however I did not find any research about the experience of child-led play with young children with emerging ND. More specifically still, I found no research that explores the experience of WMP for caregivers and professional networks of children in care with emerging ND. This is the gap in the literature that this study aims to address.

Chapter Two: Methods

2.1 Qualitative Methodological Approach

Qualitative research focuses upon words and meaning (Braun & Clarke, 2021) and aims to discover thoughts, feelings and experiences. Meaning is constructed within the context of, and relationship between, participant and researcher, who together create data which is interrogated in deep and thorough analysis. In research, the term qualitative, refers to chosen methods, for example, the processes and instruments for gathering and analysing data. Plus, more widely, methodology, for example, the framework used to make sense of the data gathered. This research is fully qualitative: I aimed to find out about individual experiences and perspectives, and I used qualitative methods and processes – semi-structured interviews analysed using RTA.

All research is underpinned by ontological and epistemological assumptions. To undertake robust and valid qualitative research it remains essential to examine these, often hidden, assumptions and their influence. I locate this research within a critical realist theoretical framework. As a researcher, I believe there is an external reality and truth that research can explore and attempt to understand. In part, this reality is empirical and observable, nonetheless there are aspects that are beyond the observable which influence observable reality. Not unlike my clinical stance which is psychoanalytic and takes account of beneath-the-surface dynamics that influence children's emotional worlds, relationships, and wellbeing.

I believe there are underlying structures, systems and relationships that influence experience and to explore participants' experience of WMP I believe I need to talk with

them. Semi-structured interviews allow me to ask questions directed by my research and allow participants to contribute their own perspectives which might go beyond my original assumptions. Other methods, which avoid direct contact with participants, such as questionnaires, are unlikely to capture such nuanced and rich data.

2.2 Researcher Reflexivity

In this study, I am researcher, interviewer, and WMP practitioner. I am known to participants in different ways and these multifaceted roles contribute to, and influence the data, findings, and meaning that are constructed through the research. Participants' experience of me as 'trainee' could contribute to questions about my experience and uncertainty about the effectiveness of WMP, while relating to me as 'researcher' could contribute to their experience of me as invested in the approach thus potentially increasing their confidence in WMP. Holding the position of 'clinician' and 'researcher' at the same time could influence the participants' responses; unintentionally encouraging a desire to praise the support I provided. I explicitly welcomed challenges and criticism, nonetheless, unconscious relational dynamics must have influenced the data I gathered. This bias cannot be fully mitigated against, and therefore researcher reflexivity is essential.

I have since reflected on the experience of interviewing in the way that I did – holding multiple positions and relationships with participants – and I recognise that the conversations held during each interview were influenced by my multiples roles. With caregivers I noticed that they continued to relate to me as clinician, sharing their child and families successes and struggles. This seemed more prominent with those caregivers who had experienced a significant gap between the interview and when we

last had contact. I recognised that I found myself pulled into this dynamic, having already established a therapeutic relationship with these children and their caregivers which increased my interest in wanting to hear about how things are now (outside of solely the research) and still wanting to support in the way I had through our therapeutic relationship. With professionals I recognise that they likely did not only relate to me as colleague but also as a representative of the service, which will have brought with it both conscious and unconscious ways of relating to me and the research. Each of the social workers has an existing relationship with me and the service, that varies from fairly limited contact to much longer-term experience and partnership working. This will have encompassed positive and negative experiences as well as voiced and unvoiced expectations and perceptions of me, of Child Psychotherapy and of the service. The scope and methods of this project meant that this level of analysis was not part of the final findings.

2.3 Design

2.3.1 Rationale and justification

I used semi-structured interviews to gather data and RTA to analyse data. I had a deductive and inductive approach to data analysis. I wanted to explore the individual experience of a range of participants – caregivers and professionals – who held different positions in relation to the children, the intervention, and me as researcher.

RTA is a qualitative methodology which accounts for different perspectives and does not require a homogenous sample; unlike other qualitative methodologies, such as, Interpretative Phenomenological Analysis (IPA) (Smith et al., 2009) which requires a

more homogenous sample. RTA is a methodology that can explore individual experience through in-depth investigation of data. RTA values researcher reflexivity and subjectivity that can be thoughtfully and explicitly considered throughout.

2.3.2 Setting up the research

I offered two brief interventions of WMP to two young children with emerging ND and their caregivers. This sparked my interest in designing the project. Both children were discharged from the service before I began the project. With ethical approval, I contacted their caregivers (foster carers of both children and adoptive parents of one child) and each of the children's social workers. Initially I wrote to them, and I followed up with a telephone call to share the research aims and request their involvement.

I wanted a larger sample, so I set up one further WMP intervention with a child with emerging ND and his foster carer. The foster carer gave informed consent before WMP began, as did a key professional from the child's professional network, with the understanding that they could withdraw at any time, and this would not affect the treatment.

2.3.3 Participants – recruitment and sampling

RTA allows for purposive sampling. The participants were a purposive sample, chosen because they received WMP and because the child had emerging ND.

Inclusion criteria:

- Received WMP delivered with model fidelity,
- Child aged zero to five years,
- Emerging ND recognised by caregiver(s) and one professional who knows the child well.

This research has ethical approval from the Tavistock Research Ethics Committee (TREC) (Appendix D). To recruit participants, originally I linked with colleagues in PIMHS. None of them had completed WMP as a standalone intervention, with a child with emerging ND, at that time. I then found three families who all agreed to take part in the research. The children in each of these families had care experience and emerging ND. I did not set out to explore children in care, but this was not an exclusion criterion. One inclusion criterion was that families would be supported by PIMHS – due to the nature of this work, children may have been more likely to have experienced disruption to early caregiving relationships. Nonetheless, PIMHS does not exclusively support children in care and/or foster carers.

It felt important to interview caregivers and professionals so I could explore the two aspects of WMP that were of most interest to me – how WMP can encourage emotional connection between young children in care with emerging ND and their caregivers, and how WMP can bring the child's experience to life, for caregivers and for professional networks who make decisions about children with complex needs. It so happened that the key professionals involved in each of these children's lives were social workers, although each of the children also had a health visitor who visited less often.

The social workers ranged from children's allocated social workers to adopters' supervising social workers and therefore held different roles within the professional networks and relationships with the children. This proved useful for gathering rich data from a diverse sample and diverse professional perspectives.

The caregivers were a diverse group of participants also, one having received WMP 14 months prior to the interview, one having WMP ongoing whilst participating in the study and for one caregiver the child was no longer placed with them, having moved on to adoption. Again, this led to rich data from a diverse sample. I reflected upon the ways in which this might influence the experience of interviewing and the data gathered – and I found myself curious to explore the extent to which WMP had stayed in the caregivers' minds as time passed and following on from transitions. In my communication with each of the caregivers whilst arranging the interviews I was struck by their eagerness to take part, and this suggested that the experience of WMP had stayed with them. For the caregiver who was mid-WMP when she took part in the interview I recognised that my ongoing therapeutic relationship with her, and the understanding that more WMP was still to come, would influence the experience of interviewing and the data gathered. In part our existing relationship may have contributed to relational safety that supported a deeper and more nuanced discussion nevertheless, I recognised that the inherent power imbalance and the participant's experience of my dual role as clinician research is likely to have influenced the data.

Participants were:

- Caregivers of three care-experienced young children with emerging ND who were supported, by PIMHS, with an intervention of WMP. For one of the

children, I interviewed his foster carers and his adoptive parents. In total, I completed four interviews with caregivers.

- One professional from the professional network of each of the three children. In total three interviews with professionals, all social workers.

Participant details:

Participant	Gender	Relationship to child	Age of child at start of WMP	Age entering foster care	Number of placement moves	Number of WMP sessions	Time since WMP
Caregiver 1	Female	Adoptive mother	3 years 1 month	22 months	1	3	6 months
Caregiver 2	Female	Foster care	4 years	18 months	0	5	14 months
Caregiver 3 & 4	Female & male couple	Foster carers	2 years 8 months	22 months	0	5	10 months
Caregiver 5	Female	Foster carer	1 year 11 months	Birth	0	6	Ongoing
Professional 1	Female	Adopter's supervising social worker					
Professional 2	Male	Child's allocated social worker					
Professional 3	Female	Child's allocated social worker					

Children who received WMP:

- Child one was four years old. He was in a long-term foster placement where he had been since infancy. He had complex developmental delay that made some aspects of caregiving challenging. His foster carers were committed and knew him well.

- Child two was two years old. He had lived with foster carers for less than a year. He had developmental delay and behaviour that challenged. His foster carers were experienced and committed. They found it challenging to make sense of his needs, that appeared to be related both to emerging ND and to early relational trauma, as did the professionals involved. He was going through the process of being adopted. He received six sessions of WMP with his foster carers, and his adoptive parents received three online sessions once he moved.

- Child three was 20 months old. He had lived with his foster carers since birth. He had restricted play interests which were difficult to understand. He was going through the process of being adopted by his foster carers.

Throughout the process of recruitment, I ensured that the offer of WMP was clinically indicated. By participating, participants were not excluded from, or delayed access to, other treatments. I delivered WMP following the manual. I received supervision from the WMP lead within PIMHS and a WMP supervision group. WMP would have been provided to participants whether or not they took part in this project.

I provided participants with a participant information sheet (Appendix E) that detailed benefits and risks of taking part in the interviews. All participants provided informed consent (Appendix F). I hoped that participants would find the interview rewarding, and it would provide an opportunity to think more deeply about their child's experience and/or the experience of supporting a child in care with emerging ND.

There are understandable barriers to involving young children in care in research, especially at times of transition. Young children in care are a vulnerable population

and their safety from harm is rightly prioritised. This can make taking part in research an unnecessary risk from which they are protected (Heptinstall, 2000; Mezey et al., 2015; Murray, 2005). Gaining consent for children in care to take part in research is complicated and can be a barrier (Oliveira et al., 2022). Although this research is concerned with that cohort, participants are caregivers and professionals, and this eliminates these barriers.

Caregivers of young children and social workers are busy and making time for interviews was challenging; I was as flexible as possible and offered online or in-person interviews. This made interviews more accessible to busy social workers (Oliveira et al., 2022). The research was qualitative and concerned with participants' experience which seemed of interest and all invited participants agreed to take part.

2.4 Data Collection

2.4.1 Rationale for semi-structured interviews

I used semi-structured interviews to collect data. Semi-structured interviews are the dominant form of interviews used in qualitative research because they generate detailed, rich data about individual perspectives and experiences (Braun & Clarke, 2021). I gathered data from seven semi-structured interviews with caregivers and professionals after the intervention. This constituted a significant and rich data set gathered from a small sample.

2.4.2 Interviews in practice

The interviews provided a containing and reflective space to explore the experience of caregivers and professionals. The interviews could have been emotionally demanding and distressing, at times, for participants. In practice this was not the case. I provided a debrief letter and offered a time to speak to all participants after the interview if needed; no participants required this.

The semi-structured interviews were slightly different for caregivers and professionals (Appendix G). For caregivers they lasted up to one hour and for professionals up to thirty minutes. I accounted for busy professionals who may find a briefer interview more manageable. I made every effort to provide in-person interviews *(n=2)*, however virtual interviews *(n=5)* were used if preferred by participants. I audio recorded each interview. In-person interviews were transcribed verbatim by a third party and virtual interviews; I met participants on Microsoft Teams and used the transcribe function which I read immediately after the interview to check for errors in the transcription.

2.5 Data Analysis

2.5.1 Rationale for Reflexive Thematic Analysis

RTA is a method of data analysis that is fully qualitative and that fits well with my critical realist position. It is flexible, versatile, and accessible which makes it appealing to a novice researcher. This flexibility does not limit the depth and richness of data that RTA can yield. RTA provides a method of analysis that allows for deep thinking and interpretation, as well as identifying themes. It can be both inductive and/or deductive which resonates with my approach, grounded within critical realism, and takes account

of observable and underlying aspects, whilst valuing a data driven approach to constructing themes. A particular strength of RTA is that it is interested in participants' personal experience which accounts for the different perspectives caregivers and professionals bring, in a way that other qualitative methodologies cannot.

2.5.2 Reflexive Thematic Analysis in practice

The process of RTA involves six phases.

Phase one – familiarising with the data. I read and re-read the full data set, noting key insights from each transcript.

Phase two – coding the data. I coded data relevant to my question. I coded the data inductively, meaning that I was led by the data and generated thoughts through engagement with the data. Initially, I returned to each interview transcript and then identified every segment of data that appeared potentially interesting and relevant. I gave these individual segments meaningful code labels. Many of the code labels were related and similar and I was able to collate them into a more concise list (Appendix H).

Phase three – generating initial themes. In the service of pragmatism and with tight time constraints and the realistic limitations of a professional doctorate, I initially organised the data using a priori codes which were in accordance with the research objectives. This involved organising the full list of coded data segments into four categories:

1. Experience of WMP for caregivers of young children in care with emerging ND,

2. Challenges of WMP for caregivers of young children in care with emerging ND,
3. Contribution of WMP within the professional network for young children in care with emerging ND,
4. Contribution of WMP to care planning.

The fourth category accounted for code labels that were specifically related to the experience of children in care and care planning. This was an area of enquiry that became of interest throughout analysis. This method for generating initial themes was helpful in supporting me to more deeply engage with the data; however, it did not support me to understand the data or fully articulate the observable and underlying aspects of the data.

I continued my analysis by moving into phase four and phase five – developing and reviewing themes and then refining, defining and naming themes. I returned to the concise code label list and engaged with this inductively to establish themes that more fully took account of the data set. The experience of initially engaging with the full data set deductively, guided by my research objectives, was helpful because it supported me to more deeply understand the full data set and the process of developing and refining themes. I noticed how a deductive approach did not fully capture the data set, nonetheless it set me up with more confidence to engage inductively with the whole data set (through the concise code label list) and I was in a better position to recognise what a data-led theme looks like and how to capture the full data set in the chosen themes.

I developed three core themes and organised the data into appropriate and meaningful subthemes.

Theme One – How WMP is Understood:

- WMP is a developmental approach
- WMP is child-led
- WMP can bring something new

Theme Two – Potential Benefits of WMP:

- For the child
- For the caregivers
- For the child and caregiver relationship
- For the professional network

Theme Three – Challenges and Difficulties:

- For the caregivers
- For the child and caregiver relationship
- For the professional network

2.6 Ethical Considerations

There were no identified risks. Participants may have found thinking in greater depth about their child's, or a child for whom they are part of the professional network, experience difficult as well as rewarding. I informed participants that if together we found out, during the interview, that either the participants, or child they care for, would benefit from further support I would make appropriate referrals with consent. This was not needed, all participants engaged fully and found the interviews manageable, no after care was required.

Contacting caregivers after the child had been discharged from the service posed some ethical questions. I wrote to them all in the first instance to give them the information about the research and some time to think about it before I contacted them on the telephone. I let them all know they were not required to take part, and they could withdraw their consent at any point during the research. All caregivers I contacted consented to take part.

Chapter Three: Findings

3.1 Chapter Structure

This chapter presents findings from the data. I will begin by returning to the thematic framework used for data analysis, then display the table of findings before discussing each of the three core themes, and their subthemes, with extracts from the data. Some extracts from the data appear within more than one theme, in keeping with the principles of RTA. This reflects an understanding that participants' accounts of their experiences are complex and multi-layered rather than conceptualised as discrete or

mutually exclusive. I found that some individual extracts meaningfully contribute to multiple themes across the data set.

3.2 Thematic Framework

Themes were developed pragmatically and evolved dynamically, moving between deductive and inductive approaches. This resulted in eighty-two unique code labels (Appendix H). I gathered these into three core themes and organised the data into several subthemes. I created a detailed findings table containing all code labels (Appendix I) and a concise table of findings.

3.3 Table of Findings

1 How WMP is Understood	2 Potential Benefits of WMP	3 Challenges and Difficulties
WMP is a developmental approach WMP is child-led WMP can bring something new	**For the child:** Positive experiences for the child WMP promotes child-led play by providing individual attention WMP meets the needs of children with emerging ND WMP supports children facing transitions **For caregivers:** Positive experiences for the caregiver Focus on attuning to and understanding the child through undivided adult attention A different way of being with the child Supporting caregivers to meet the needs of children in care **For the child-caregiver relationship:** Quality time Relationship building **For the professional network:** Positive experiences for the professional network Better understanding of the child	**For caregivers:** Doing things differently Timeliness of WMP Time investment **For the child-caregiver relationship** Being together **For the professional network** Understanding the approach Involvement

3.4 Code for References in Data

Professionals	PF
Caregiver	CG
Page	P
Line	L

3.5 Theme One – How WMP is Understood

3.5.1 WMP is a developmental approach:

WMP can take account of children's holistic development and be tailored to children's changing needs. The flexibility of WMP was highlighted by a social worker who talked about how the aims of WMP changed and developed as the child did. She said:

> *"I felt … that changed [the aims] through the course of the intervention because he changed actually, I think, through the course of those six weeks." (PF3/P24/L15)*

WMP does not exclude children with developmental delay or emerging ND. A social worker described that WMP, rather than relying on words, harnesses play as the means for communicating, getting to know the child and being together. Because of this play-based and child-led focus, WMP is inclusive and accessible to children with emerging ND. He said:

> *"Using the play as a dialogue with him … that was really, really useful, and it was a medium that seemed to work." (PF2/P20/L1)*

This is important for young children with emerging ND, where communication and other forms of connection can be difficult. Using play as the dialogue can encourage

opportunities for connection and communication. WMP facilitates interactions between children and caregivers that promote child development through increasing opportunities for child-led play. A foster carer described how:

> *"It's great when you can do all that through play." (CG3/P49/L29)*

WMP was originally designed for use with children in care and their caregivers, and it can be particularly helpful with this population. There are other interventions and approaches that are designed for work with young children in care; a social worker described similarities between WMP and another approach:

> *"I thought there was a little bit of a link with the PACE model … 'no correction, without connection' … So, it was all about engagement with him. We can't use words, and in some ways, he has to lead the engagement." (PF2/P20/L12-22)*

This statement highlights the important focus on child-led play in WMP, when other ways of engaging, such as with words, can be difficult. A foster carer highlighted that WMP combines principles from several approaches, including the PACE model and other trainings, stating:

> *"I think when we did the nurturing training and the trauma training, the Solihull, … I think … that was put together in the WMP" (CG3/P41/L12)*

WMP has many similarities to PACE and Solihull, which have been recognised by participants, and yet there are some distinct differences that make WMP unique.

3.5.2 WMP is child-led:

Participants spoke frequently about child-led play. This appeared important to all and stayed with them as a defining aspect. Throughout the interviews participants described their personal perspectives of what had defined WMP, for example, an adoptive parent described:

> *"Just letting him lead a lot." (CG1/P89/L16)*

> *"Not sort of dictating how things go." (CG1/P51/L27)*

A social worker noticed, and spoke about, the role of the caregiver in WMP when providing child-led play. He defined this as:

> *"Showing interest in the child." (PF2/P4/L1)*

> *"Being on his level." (PF2/P12/L30)*

> *"Trying to see the world through their eyes." (PF2/P11/L9)*

A foster carer described how valuable it had been for her child when she had followed his lead:

> *"I think the biggest thing is it gave him choice." (CG2/P13/L15)*

Another foster carer explained that watching their child's play, when they were given free choice, supported her and her husband to get to know him better and understand his likes. She said:

> *"It's like knowing that that might have been his favourite things because he was choosing them himself as opposed to us saying: 'ohh shall we play with this, shall we play with that.'" (CG3/P24/L29)*

3.5.3 WMP can bring something new:

Participants spoke about how WMP provided new insights. A social worker shared that this was a hope she had when starting out:

> *"I just went along with it thinking well, I would see what happens if we … get some interesting insights from it." (PF3/P16/L14)*

This professional is expressing some ambivalence about the approach; nonetheless, she highlights the potential of WMP to provide some new insights. Another social worker shared that WMP did create new insights, which he found helpful. He said:

> *"It's just very helpful and added insight." (PF2/P31/L31)*

As well as providing new insights, participants talked about how WMP added something new they had not expected, for example, an adoptive parent shared how WMP created a fundamental change in the way she played and interacted with her child. She said:

> *"It's not just by the box itself, not just by that time, but it was helped by changing how we interact with him. I guess as a whole … I … tried to be less, directional and letting him do what he wants to do." (CG1/P56/L24)*

This caregiver described her expectations of the aspects of WMP she thought would create change, for example, the box of toys and the time together. What she found was the process of change was deeper and led to fundamental shifts in the way she interacted with her child, becoming less adult-led and providing him more freedom and

choice to lead his play. She recognised this as the agent of meaningful change which enabled a new way of being with her child.

3.6 Theme Two – Potential Benefits of WMP

3.6.1 For the child

3.6.1.1 Positive experiences for the child:

Participants made many comments about how WMP had offered the child positive experiences. The range of experiences related to those which would be universally positive for all children, for example, social workers described how:

> *"He enjoyed the sessions." (PF3/P7/L8)*

> *"I think he probably felt more understood over time." (PF2/P13/L19)*

Caregivers made similar observations, sharing that WMP:

> *"Makes him feel like we're there for him rather than we're telling him what to do all the time." (CG1/P88/L15)*

More specifically in relation to children with emerging ND, a foster carer explained an unexpected and pleasing development – that her child quickly learnt what WMP time was for and made a link between the WMP practitioner coming to visit and the box of toys.

> *"It was instant routine. He knew when you walked in, he got the box out." (CG2/P11/L5)*

3.6.1.2 WMP promotes child-led play by providing individual attention:

Participants talked about WMP promoting child-led play through providing individual attention. They articulated several benefits of child-led play for children in general, and more specifically for children with emerging ND. These benefits included the child playing for longer and sustaining their attention throughout WMP more than other play times. A foster carer explained that WMP:

> "*Kept his attention for the whole time." (CG4/P15/L8)*

Caregivers described some benefits related to the way it made the child feel, for example:

> *"They know they've got your 100%." (CG3/P30/L3)*

Another caregiver commented that WMP:

> *"Makes him feel like we're there for him rather than we're telling him what to do all the time." (CG1/P88/L15)*

This was talked about as especially important for young children with emerging ND because caregivers found it more difficult to know about their child's interests. Taking part in WMP helped caregivers develop a better sense of what their child liked to play with. A foster carer explained:

> *"Like knowing that might have been his favourite thing because he was actually choosing them himself." (CG3/P24/L29)*

3.6.1.3 WMP meets the needs of children with emerging ND:

Participants shared that WMP worked well for children with emerging ND. A social worker said:

> *"But in terms of WMP and my understanding of that, it's a model which accepts the … neurodiversity, and the complexity of the way children think and develop." (PF2/P10/L31)*

There seemed to be several important elements of WMP that made it accessible for this cohort. This social worker highlighted that WMP is inclusive and accepting of children's complex needs, and he recognised how WMP made the child feel:

> *"I think he felt accepted … He felt very included." (PF2/P18/L8-26)*

A further valuable element for children with emerging ND, was that WMP is repeated and regular. A foster carer explained:

> *"He knew that it [WMP] was gonna happen again afterwards." (CG3/P32/L3)*

This foster carer noticed how their child came to understand that WMP was part of their weekly routine. When each session came to an end he was able to tolerate the emotional experience of ending because he felt assured more WMP was to come. These kinds of reliable routines can be particularly important for this cohort and their caregivers.

WMP can be provided at a child's home, in-person or online, in a clinic or in their education setting. Two foster carers spoke about how helpful it was that WMP was offered in their child's home, where he felt most safe and comfortable. Without this

their child would not have been able to take part, just as they had not managed to take part in other interventions. A foster carer said:

> *"He was just finding it [speech and language therapy] too stressful because it was a different place, more people." (CG3/P10/L15)*

This child's struggles with going to new places with new people, which could be busy and noisy, was described as specifically related to his emerging ND. By reducing these extra stressors, he was able to relax and join in with WMP at home. Another foster carer mentioned that WMP would be accessible for her child if offered at home or in his school, but anywhere else, she believed would be unmanageable for him.

> *"The biggest benefit I think for [my child] was it was in his house." (CG2/P17/L21)*

This was important for the child, but also important for their caregiver, because it communicated an understanding and recognition of the child's needs and demonstrated flexibility and willingness to adapt WMP for the child and their family.

3.6.1.4 WMP supports children facing transitions:

For two of the children, WMP was used before and after transition between foster care and adoption. When young children are in care and facing transitions, they are supported by a network of professionals who work together to create a plan that supports a successful transition where possible and appropriate. There are legal frameworks in place and processes to be followed. One caregiver talked about not always feeling heard by professionals particularly during planning around

introductions. She talked about social workers who seemed to have a rigid plan for when the child would meet their adoptive parents, and she felt this plan might not consider the child's individual needs. She said:

> *"They [social workers] needed to know that every child's an individual, they don't always follow that same pattern." (CG3/P48/L19)*

A social worker spoke about the way she approaches supporting children in their move to adoption, she shared thoughts about what children need during transitions. She said:

> *"Generally, when we're working, you know, working towards adoption … We're not gonna be introducing another professional, certainly to work with the child on a one-to-one basis anyway." (PF3/P31/L12-22)*

At times of transition, it is understandable that professionals think carefully about introducing new professionals to a child who will be expected to say goodbye to important adults and build new relationships with their adoptive parents. This social worker was expressing a concern about offering direct therapeutic work to a child during this time. Other participants, however, talked about support from WMP at this time, which provided an experience of continuity and familiarity. A social worker said:

> *"So, there was continuity there for him because we were desperately trying to keep everything the same." (PF1/P16/L18)*

This social worker shared some relief that WMP was available to the child before, during and after such an important transition because it offered continuity of the type of experience provided to the child, at a time of lots of change. An adoptive parent talked about how important it was for her child to access WMP during and after the

transition because it was something that came with him from his foster carers. She said:

> *"Yes, he does really value things that came from the foster carers. So, I think that was part of it as well. [The WMP box] was something that he had from them, and that sort of diminished over time, but we do still say things like, oh, this came from your foster carer's and then he's like, "Ohh!" So, I think it is nice to have the familiarity." (CG1/P82/L21)*

A social worker recognised the value of this familiarity between foster carers and adoptive parents. She said:

> *"I think maybe for [the child] having some familiarity from before, to when he was placed at home – that box, and the toys, were with him and were still there when he moved. That may have helped him." (PF1/P16/L5)*

This is a related but slightly different point – more in terms of general routines which include endings and transitions. Several caregivers and professionals spoke about how WMP supported their child to manage endings and transitions. One foster carer said:

> *"He'd always struggled with [endings], but I think the WMP did help." (CG3/P25-26/L29-1)*

This caregiver illuminated a problem her child had with managing endings and shared how WMP helped him with that. In WMP there is a clear structure that stays the same and becomes predictable. This child and caregiver have repeated experiences of WMP providing a structured time with a beginning, middle and end that can make

endings feel more manageable. The caregiver can generalise this to other moments when they move between activities, people and places.

3.6.2 For the caregivers

3.6.2.1 Positive experiences for the caregiver:

Caregivers talked about enjoying WMP, sharing that they found it helpful and interesting and that it gave them confidence. One foster carer said:

> *"I did find it interesting, and I did learn from it." (CG4/P13/L7)*

Taking part in WMP empowered caregivers, led them to feel a greater sense of agency, validated what they were doing, and helped them to believe and hope that things can be different, and development can take place. Another foster carer said:

> *"WMP, it makes you think, well, what can I do? What can I tweak?" (CG3/P51/L12)*

This is helpful for all caregivers, but particularly caregivers of children in care or with emerging ND, who might feel isolated and desperate. A foster carer said:

> *"I think sometimes, you feel a bit like you're on your own." (CG4/P13/L17)*

Caregivers appreciated the practitioner getting to know their child and seeing them in the same way they did. This seemed related to the practitioner's capacity to give the caregiver and child enough time to get to know them which provided caregivers with some relief and gave them an experience of feeling known themselves and validated.

> *“I know that there’s something with [child], but I don’t think many people understand because nobody sees it like I do. So, it’s nice to have somebody else come in and see a bit of what I see, because … a social worker comes for an hour visit and she’s just got what I’m telling her, she’s not spending the time seeing for herself. (CG4/P13/L18)*

Several participants discussed carrying on with WMP since the sessions finished. One foster carer has continued prioritising one-to-one child-led play with the babies she now cares for. She said:

> *“We do still continue with that, and we try to have 10 minutes in the morning and 10 or 15 minutes in the afternoon.” (CG3/P37/L30)*

Another foster carer made sure to always get down on the floor when playing with their child and to keep offering him choice. When asked if she had continued with any aspects of WMP, she said:

> *“Yes, because I do the one-to-one on the floor, and we do the playing, and the choice.” (CG2/P20/L9)*

Similarly, an adoptive parent used WMP to provide more quality time between their child and his father to encourage a bond to develop.

> *“It was just getting him a bit more bonded with [his adoptive father]. I don't know if it's ‘attachment’ or ‘bonding’ or what the specific terms are, but you know, just getting him happier to be around [his adoptive father]”. (CG1/P57/L19)*

3.6.2.2 Focus on attuning to and understanding the child through undivided adult attention:

These comments overlap with comments in section 3.6.1.2 which articulates the benefits of individual attention for child-led play, whereas the focus here is on benefits for the caregiver. Several participants spoke about how WMP increased focused adult attention towards the child; most caregivers felt this complemented what they were already doing or how they wanted to be. This kind of focused attention is important for all young children, as was picked up by one foster carer who explained:

> *"All children need that, yeah, they just need your undivided attention." (CG3/P38/L21)*

A professional noticed that WMP supported caregivers to offer this focused attention, and it gave them opportunities to think about their child's play. In this way, they were helped to better understand their child. He said:

> *"Using the play as a kind of way in." (PF2/P19/L26)*

He noticed that by attuning to the child, adults were:

> *"Accepting their way of thinking." (PF2/P11/L8)*

This was discussed in relation to all children, and as most important for children with emerging ND. One social worker described the approach as:

> *"More visiting him in his world really." (PF2/P24/L24)*

Participants particularly talked about how WMP contributed to a better understanding of their child's play, development, behaviour, and their emotional world. An adoptive parent said:

> *"And it just makes me think that … sort of attention seeking is him not feeling very good and not very comfortable rather than not being able to play on his own." (CG1/P14/L24)*

This caregiver demonstrated how WMP can support caregivers to find meaning in their child's play and behaviour which she noticed communicated something about his emotional world and state of mind.

3.6.2.3 A different way of being with the child:

Another benefit, discussed by participants, was how WMP gave caregivers an experience of a different way of being with their child. Mostly caregivers spoke about being less directive, for example, an adoptive parent said:

> *"I had to hold back." (CG1/P64/L1)*

Participants spoke about how WMP encouraged them to offer their child more choices. Caregivers noticed their child enjoyed this and they themselves benefited from developing a better understanding of what their child liked and disliked and noticed developments in their child's capacity to play for longer. This seemed to increase caregivers' interest in their child's minds. A foster carer said:

> *"Like knowing that might have been his favourite thing because he was actually choosing them himself." (CG3/P24/L29)*

A further important benefit was that caregivers felt they had developed a capacity to be interested about themselves, as well as their child, and described becoming more self-reflective. An adoptive parent shared that:

> *"It's interesting to like sort of notice yourself as well." (CG1/P54/L20)*

In noticing herself, in this way, she was surprised by what she discovered about the way she plays with her child. She said:

> *"I was surprised at myself … I thought I'd just let children get on with it … but I clearly didn't so I did feel I had to hold back sometimes." (CG1/P63-64/L30-1)*

This caregiver shared how WMP encouraged her to explore how she played with her child and helped her to notice that she had been more caregiver-led and directive than she had thought. This allowed her to make changes to the way she played with her child, holding back, and letting him lead.

3.6.2.4 Supporting caregivers to meet the needs of children in care:

Caregivers of children in care are likely to require support to meet their child's needs. Children in care often require tailored support for their development, relational and emotional needs and this can be challenging. A foster carer expressed that WMP had given her vital support to continue caring for her child. She explained:

> *"We would have been lost without [WMP]!" (CG3/P49/L4)*

For caregivers, getting to know about their foster child's early experiences can be disturbing and confusing. WMP can help caregivers provide children with play and

understanding, so they can get to know one another in a way that feels safer. A foster carer said:

> *"But obviously when you get a foster child, nobody knows what they've been through, what they've heard, what they've seen… So, it's so important to give that to them [play and understanding]. I think when we did the nurturing training and the trauma training, the Solihull, and I think sometimes that was put together in the WMP." (CG3/P41/L3-13)*

This caregiver talked about drawing on a range of approaches to help her think about her foster child's emotional world and early history. She recognised similarities between a range of trainings and approaches, including WMP. Having these approaches to draw upon helped her get to know about her child's difficulties and experiences.

In talking about her experience of WMP with her child, an adoptive parent became more in touch with her child's emotional experience of moving between foster care and adoption. She said:

> *"I think … the time, like transferring from [foster carers] to us, would have just been horrendous for him, I guess, internally." (CG1/P95/L29)*

Children in care experience painful and confusing separations and transitions between caregivers. This can lead to separations feeling very difficult to bear. An adoptive parent noticed that WMP offered her child and his father opportunities to spend more time together which supported their relationship to grow and develop. She said:

> *"Just getting him to be happier around [his adoptive father]." (CG1/P57/L21)*

In turn, WMP helped their child manage, over time, to tolerate some separation from his adoptive mother. She shared that WMP helped her, and her son manage some moments apart because it provided structure and focused time for her son and his adoptive father which helped them bond. She said:

> *"Just having something that was separate to me as well." (CG1/P51/L19)*

3.6.3 For the child-caregiver relationship

3.6.3.1 Quality time:

Participants reported that WMP benefited the child-caregiver relationship by encouraging caregivers to make time to be together. This was discussed, for example, by an adoptive parent who recognised that WMP provided an invaluable opportunity for one-to-one time between their child and his father.

> *"I think it did help him to have a little bit of time with [his adoptive father.]" (CG1/P63/L5)*

She talked about how prioritising time together to do WMP, which was something structured, helped father and son be together and bond.

Another participant recognised that WMP encouraged her to prioritise time together with her child that was free from disturbance. Prioritising time and adult attention for the child is something she found valuable, and she continues to offer this kind of time and attention to foster babies she is caring for now.

“We do try and have that structured time … While we're doing this, we're just doing that, and if my own children are at home, I just say to them, look, don't come in here either, for a minute, we're just doing this. So, it's just trying to have that space without getting that … disturbance.” (CG3/P38/L3)

3.6.3.2 Relationship building:

As well as encouraging caregivers to prioritise time together to benefit the child-caregiver relationship, several participants discussed how WMP supported other aspects of relationship building. This included increasing caregivers’ capacity to have empathy towards their child. One foster carer said:

“It gave us an understanding of what he was going through.” (CG3/P49/L5)

By watching the child’s play and thinking about it, this foster carer was able to develop a better understanding of what her child had been through.

WMP encourages caregivers and professionals to meet the child where they were at. This was demonstrated by a social worker who said:

“Trying to be on the same wavelength.” (PF2/P4/L1)

In this way, it was felt WMP could assist caregivers in unpicking complex relational and developmental difficulties and support the child and caregiver to bond.

“It was just getting him a bit more bonded with [his adoptive father]. I don't know if it's ‘attachment’ or ‘bonding’ or what the specific terms are, but you know, just getting him happier to be around [his adoptive father]”. (CG1/P57/L19)

In addition, participants talked about how WMP helped their child manage stressful routines, such as tidying up time and mealtimes, making these routines more enjoyable through caregivers incorporating playfulness. A foster carer said:

> *"[WMP] made it more of a game for him doing that, the whole thing, get the toys out, the toys back in the box." (CG3/P31/L26)*

She recognised that both playfulness and structure in WMP helped her child manage tidying up and endings in a new and different way. A foster carer described something similar at mealtimes:

> *"Food, and the snacks, we made it, you know, more playful so that it wasn't such a stressful thing for him." (CG3/P51/L15)*

This foster carer talked about making changes to the way they gave their child meals and snacks. Having more enjoyable times together, inspired by WMP, helped reduce stress and in this way enhanced the child-caregiver relationship.

3.6.4 For the professional network

3.6.4.1 Positive experiences for the professional network:

Professionals shared a range of positive experiences which included appreciating the approach and finding it helpful. A social worker described how WMP contributed to a surprisingly successful outcome for a child he supported.

> *"It was a … new experience for me … and I think in terms of the cases that we've got, I think that the case of [child] and the success of how far he's come. Yeah, it's been … a bit of a triumph." (PF2/P22/L27)*

Other professionals noticed that WMP served to reassure anxious professional networks; it gave them confidence and offered hope. A social worker said:

> *"I think it gave the professionals confidence that we had got something that was in motion for the child ... I think it gave us all some more confidence that there was something there that the adopters could tap into." (PF1/P19/L18-30)*

This suggested that the professional network felt relieved to know that WMP support was available for adoptive parents once their child was placed. She talked about the professionals having more confidence which reduced their anxiety and freed them up to work together and make decisions.

Professionals recognised that successful WMP had an impact on decision-making by the professional network, for children in care. A social worker said:

> *"The mindset in WMP was used in terms of the way the transfer was made, to do it, obviously, to do it at the child's pace, to transfer the attachments, to use transitional objects as well, to make the transfers in places that the child felt comfortable." (PF2/P30/L5)*

This suggests that the WMP approach sharpened the focus of the decision-making professional network on the needs and experiences of the child.

Participants recognised that WMP supported the work of professional networks and that using the approach successfully relies on professionals working together. One social worker explained:

> *"The approach lies really in the team around the child approach." (PF2/P32/L1)*

Another social worker shared how important it had been to meet regularly to think about WMP and review its progress, commenting that it had been:

> *"Quite helpful having those kinds of meetings all together as well for the professional network." (PF3/P25/L5)*

When professionals felt that WMP had been successful, they talked about it with their colleagues. A social worker said:

> *"Certainly, when I had supervision with my manager, I talked to her about how it was used." (PF2/P21/L3)*

This is one way awareness of WMP can spread, and interest in WMP can increase.

3.6.4.2 Better understanding of the child:

In addition to providing the professional network with positive experiences, participants talked about how WMP provided opportunities to develop their understanding of the child. Professionals described discovering new insights and perspectives in relation to the child's emotional world. The development of insight is especially important for networks working with this cohort because being with these children can, at times, leave professionals disturbed and confused. A social worker said:

> *“It was a little bit of a window, and because I don't mind saying that when I first met him, I thought: how are we going to engage with him because he pushes people away?” (PF2/P19/L8)*

The experience of developing better understanding was spoken about as having a profound impact on professionals themselves, including giving them hope. A social worker explained:

> *“It's made me feel that some of these children that we perhaps worry are lost, can actually be retrieved.” (PF2/P32/L8)*

There was an acknowledgement that WMP helpfully developed a shared language for professionals and caregivers to think about the child. This has the power to deepen understanding and connectedness within professional networks. A social worker shared that:

> *“It was helping the adopter see him through the same lens that you’d given the foster carers.” (PF1/P16/L17)*

Having this type of continuity in thinking about the child’s experience and development is helpful for the child who can continue to feel understood by their caregivers. It is helpful for professionals and caregivers who feel they have a shared language to describe the child in a meaningful way, that they can be heard, and that their experience of the child is validated.

Having a better understanding of the child helps to energise professionals. This helps them persist, and remain hopeful, with work that feels hard and can be painful. Supporting children and families where there are high levels of distress and disturbance can take an emotional toll on professional networks. WMP, in supporting

professionals to develop a deeper understanding of the child's play, development and behaviour, can help professionals feel what they are doing is important and is making a difference. A social worker said:

> *"Some of his behaviours, the progress, the fact that the progress wasn't linear, two steps forward and one step back … Uh, and I think it takes a little bit of a psychological toll. If you can say that, on the carers, and sometimes on the professionals as well. It's because you can get this sort of idea of, well, nothing works, and I think it's about resilience … persisting with the program, not giving up." (PF2/P20/L10-31)*

3.7 Theme Three – Challenges and Difficulties of WMP

3.7.1 For the caregivers

3.7.1.1 Doing things differently:

Caregivers shared that WMP had been challenging for them. An adoptive parent said:

> *"The challenges I guess were mostly the adult's." (CG1/P78/L21)*

Caregivers explained being involved with WMP led to learning something new. A foster carer said:

> *"It wasn't as much for him learning, it was … probably more us learning." (CG3/P23/L33)*

Some participants found WMP was challenging because it was difficult for them to see the way the approach involved doing things differently. They had felt that WMP did not

offer anything new or different, explaining they already played with their child. A foster carer said:

> *“I do already do, I sit on the floor, and I do play with him anyway.” (CG2/P11/L21)*

This highlighted a challenge for caregivers in fully understanding the ways in which WMP involves a different way of being with their child. For example, rather than playing with the child, WMP involves caregivers watching their child’s play, talking about their play, joining in if their child invites them to but still following the child’s lead.

Other participants found WMP challenging because they recognised that it asked them to do things differently. These caregivers described appreciating support from the WMP practitioner which helped them to be with their child in a different way. A foster carer said:

> *“I’ve definitely learnt to stop teaching and asking questions.” (CG4/P18/L20)*

Participants were able to describe how they felt WMP asked them to do things differently and what they found difficult. The child-led play and non-directive aspect of WMP felt different and challenging for some, nonetheless eventually beneficial. An adoptive parent said:

> *“I thought I'd just let children get on with it and, but I clearly didn't.” (CG1/P64/L1)*

This adoptive parent was able to recognise that she was more adult-led in her interactions with her child than she had thought.

Other caregivers found it challenging to maintain undivided attention on their child's play, particularly for those who described finding their child's play restricted and difficult to understand. A foster carer said:

> *"I find it quite hard to carry that [WMP approach] on because his play is so limited." (CG4/P16/L1)*

Caregivers tended to want to intervene and direct their child's play:

> *"I did sometimes find it hard not to be like, 'Ohh, why don't we do this?'" (CG1/P54/L12)*

Participants talked about what it was like having a child with emerging ND. Some caregivers felt worried about whether their child could play, learn, and develop and they noticed that these worries led to them being more adult-led and directive in play. Caregivers reported WMP helped them to do something different in play and notice more about their child's development. A foster carer said:

> *"Sometimes, I just fell back into that habit. I think with me, it was because I was so worried that he was going to have delay, I think that's why I've been such a teacher with him, but he's really bright and clever. So, I think I can kind of calm down a bit now and just play." (CG4/P19/L7)*

This highlighted how challenging it can be for caregivers to sit with worry and uncertainty about their child's development. Being directive and in a teaching position is likely to give a feeling of doing something, which can increase the sense of agency, but at the cost of reducing the child's opportunities to engage in child-led play.

3.7.1.2 Timeliness of WMP:

Participants talked about the timeliness of the provision of WMP support. Some participants expressed they would have wanted to have WMP sessions sooner, particularly when thinking about children in care. A foster carer said it would be:

> *"Far more beneficial to a carer when the child has first come to them". (CG2/P10/L1)*

Thereby they articulated an appreciation for WMP whilst sharing some disappointment about receiving it when they did and becoming aware of how much it might have helped when their child first arrived. An adoptive parent who received WMP support when her son arrived with them commented that this timing had worked well:

> *"It's specific to our situation, or any other like adoptive parents, I think that it's a really good time to do WMP [at the beginning]." (CG1/P80/L26)*

Participants also wanted to have WMP support as early on as possible in relation to their child's emerging ND. A foster carer said:

> *"If the carer has not had a child with additional needs before, it would be very beneficial to get in earlier, rather than later." (CG2/P23/L8)*

This demonstrated how caring for a child with emerging ND can be complicated and require adaptations. This participant recognised that WMP could help foster carers think about their child's development and additional needs which she felt would be helpful in getting them off to a good start together.

Several participants recognised since WMP supports relationship building, providing this support as early as possible when relationships are just getting going would be ideal. An adoptive parent said:

> *"The quicker you get the relationships going the better." (CG1/P81/L14)*

Another issue in relation to timing was that some caregivers were unsure about whether WMP could help to begin with. They needed time for it to begin to make sense. A foster carer said she had to:

> *"Go into it very open." (CG2/P9/L26)*

This foster carer raised an important point about whether caregivers can feel committed to WMP and convinced it can offer something helpful from the start. She said:

> *"To be honest with you, it was more of a refresher than anything else for me, I think. Like I said, I can fully understand the benefits of it, and I think it's really, really good. But I just think for the purposes of me at that time, it probably wasn't the best thing to do." (CG2/P10/L25)*

It may be the case that the aims were not made clear enough or agreed on when WMP was introduced, or perhaps a shared understanding was not established as to why WMP might be helpful for this caregiver and child at this time. If this were so, a lack of consensus could have got in the way of the caregiver feeling committed to trying the approach – raising issues for recommendations for practice which are discussed in the conclusion.

3.7.1.3 Time investment:

Participants recognised that it could take time to see benefits from doing WMP. A foster carer commented:

> *"It takes time." (CG3/P4/L1)*

This participant highlighted that benefits of WMP do not always happen quickly. As all the children thought about in this research were in care and had emerging ND these may all have been families who needed a longer period of support.

Participants also recognised that it took time for caregivers to learn about WMP and feel confident to take part. An adoptive parent said:

> *"Practice makes it more second nature." (CG1/P56/L12)*

Thus, they noticed that WMP might not come naturally and might require practice, and yet once it is established caregivers feel more confident to implement WMP.

Another participant felt that WMP was the right approach, but it did not necessarily help with their biggest concerns; it could be that more time was needed to address these concerns, or other interventions may have been needed alongside or after WMP. She said:

> *"It just wasn't necessarily helping with the like immediate or the most critical things at the time … I think just with the aggression, we still get it quite a lot and it's not just like toddler lashing out." (CG1/P92/L21-29)*

This highlighted the importance of setting up WMP in such a way that everyone understands the aims, how long the approach will last, and that there will be regular

reviews to ensure the most pressing concerns are addressed and what further or additional support is needed for the family.

3.7.2 For the child-caregiver relationship

3.7.2.1 Being together:

Participants recognised that being with, and giving individual undivided attention to, a child in care might feel different from being with children who are not in care. A foster carer said:

> *“When you get a foster child, nobody knows what they've been through, what they've heard, what they've seen.” (CG3/P41/L3)*

This foster carer reflects on how much anxiety there can be when caring for young children with painful and disturbing early histories. This might make it more difficult to be with the child and watch their play.

Another caregiver described that the way their child elicits attention can be distressing and hard to understand. WMP helped this caregiver feel they were providing their child with attention in a positive way, rather than a response to his emotional dysregulation which had previously been the way he sought attention. She said:

> *“Trying to not like reward him … but you know, trying to make the more subtle signs a positive experience rather than him, you know, only getting attention from us when he's, like, very dysregulated.” (CG1/P9/L9)*

3.7.3 For the professional network

3.7.3.1 Understanding what the approach involves:

Participants talked about their experience of finding out about WMP. Professionals explained that they did not know about WMP before it was offered. A social worker said:

> *"I hadn't heard about it." (PF1/P5/L34)*

All participants described being offered WMP rather than asking for it themselves. A social worker said:

> *"So, it was suggested by the PIMHS team, it's not that I went to seek it out." (PF3/P16/L6-14)*

Worries were shared about how suggesting WMP can increase anxiety if the offer of support is felt to be a judgement. A social worker said:

> *"I do have a bit of concern that if it's described as being about relationship building and things that some carers might feel quite put out." (PF3/P33/L2)*

This was a specific concern for social workers supporting foster carers who felt that talking about support around relationship building might lead to foster carers feeling judged or criticised.

Once WMP was identified and offered, most participants explained they were not clear about what the approach was or what the aims were, particularly at the beginning. A social worker said:

> *"I wouldn't have known the specifics." (PF1/P6/L9)*

However, another professional felt they understood the approach at this point but were concerned that the approach suggested providing child-led play rather than more adult direction. They worried that for a child who appeared distressed and disorganised this could lead to more disturbance. He said:

> *"I think the natural instincts of any foster carer in that situation, when a child is very chaotic, is to try and direct and control them. So, it was almost … like the WMP was a little bit counter intuitive." (PF2/P3/L15-23)*

A participant explained that they felt it was important for professionals and caregivers to have a good sense of what the approach was and the aims, specific to each child, right from the start:

> *"From the beginning to be really clear with professionals and the carers about why we're doing this, what's the aim." (PF3/P29/L12)*

The same professional noticed that meeting together with the practitioner and the caregiver to think about the progress had been helpful to get a better sense of the approach and the aims:

> *"Once we discussed it with you and asked a few questions, all three of us together, I think it was a lot clearer to both of us." (PF3/P25/L5)*

It was important that professionals felt they understood when WMP might be appropriate. A social worker said:

> *"Without listing all the specific scenarios where it may help, just having a broader understanding of the actual intervention and its aims would then allow*

me, I think, to be able to think more widely about how it might be beneficial in different circumstances." (PF3/P15/L15)

Recognising that she would be helped by having a clearer understanding of what WMP was and the different ways it can help families, this social worker felt that she could be more confident when recommending WMP to caregivers.

3.7.3.2 Involvement:

Some professionals described just going along with WMP, without being particularly invested or interested in the approach. This seemed to occur more at the beginning and lessened once WMP became established. A social worker said:

"I just went along with it thinking well, I would see what happens if we … get some interesting insights from it." (PF3/P16/L19)

This indicated that, similarly to caregivers, as discussed in section 3.7.1.3, professionals needed time for WMP to begin to make sense to them.

Professionals expressed concerns about how WMP could be relevant for their work. A social worker said:

"I'm not sure what I, as a professional in my role, … would be hoping to gain from it." (PF3/P30/L4)

There was a sense that some professionals were too busy for approaches like WMP. A foster carer said:

“But social workers don’t really. You see them for an hour, and they haven’t got the time to invest have they, like you have.” (CG4/P21/L5)

Most participants mentioned that a joined-up professional network was needed. Nonetheless, as these professionals are not those who actively implement WMP they are likely to feel less involved. A concern was shared that professionals needed some sense of involvement in order to understand WMP and for the WMP work to influence the professional network. A foster carer said:

“I don’t think they’re involved enough for it to have an effect.” (CG4/P20/L18)

Chapter Four: Discussion

This chapter follows the same structure as the findings, further exploring themes and subthemes discussed there and making links between the findings and literature.

4.1 Theme One – How WMP is Understood

4.1.1 WMP is a developmental approach

The findings highlighted that WMP was found to be accessible, inclusive and helpful for development, through facilitating child-led play, and that was especially important for this cohort. Several authors explained that increasing opportunities for child-led play is vital for children's learning and development, social and emotional wellbeing and relationships (Meins et al., 2013; Music, 2016; Smith, 2005).

Promoting development through child-led play is especially important for this cohort who are particularly vulnerable and are likely to achieve poor developmental outcomes (Parsons et al., 2019). For these children, child-led play can be compromised due to concerns about their development (Rhode & Grayson, 2018) which may lead caregivers to become increasingly directive towards their child's play in an attempt to relieve anxiety about their child's capacity to learn and develop. Furthermore, being together in this way requires caregivers and professionals to be emotionally in touch with the child's previous trauma and loss (Browning, 2015; Wakelyn, 2019c) which is understandably difficult and may require support for the caregiver.

It was noted that WMP can adapt to the developmental needs of the individual child. Research and policy documents highlight how important it is to provide the right

support early on, especially to those children most at risk (National Scientific Council on the Developing Child, 2020; O'Meara et al., 2022). The population of young children accessing mental health services is inherently complex (Cottrell & Kraam, 2005) and therefore approaches need to understand, and be flexible and responsive to, children's development and changing needs. Young children with emerging ND have vastly different developmental needs and achieve hugely different developmental outcomes. Therefore, no single intervention or approach has been found to help this demographic (Kanner, 1995; Rhode & Grayson, 2018). Nevertheless, approaches that provide experiences that promote development and increase protective factors associated with resilience were found to be most effective (Evangelou et al., 2007) and there was a consensus that development takes place within supportive relationships (O'Meara et al., 2022; RFCEC, 2021).

Both professionals and caregivers, recognised similarities in the principles of WMP and other interventions for this cohort. A social worker made links to the DDP PACE (Hughes, 2006; Golding, 2018) approach with its focus on "no correction without connection" (PF2/P20/L12-22) which led this social worker to think about the way WMP supported the child to "lead the engagement" (PF2/P20/L12-22). Both comments highlight the relational and child-led focus of WMP. A caregiver commented on how she could see similarities not only with DDP but also with the Solihull Approach; she explained that these different approaches were "put together in the WMP" (CG3/P41/L12). Here WMP is considered to be an approach that provides important developmental experiences (Wakelyn, 2019a, 2019b, 2019c, 2019d, 2025). The data indicates that both caregivers and professionals valued the flexibility, accessibility and inclusivity, which means that WMP can take account of the individual child's development.

4.1.2 WMP is child-led

WMP was defined by participants as child-led and this was felt to increase caregivers' understanding of their child and support relationship building. The vital nature of child-led play is widely referenced (Music, 2016; Panksepp, 2007; Wakelyn, 2019b). Approaches with young children describe supporting child-led play to improve caregiver-infant relationships, caregiver sensitivity and responsiveness (Lojkasek, 2025; Wakelyn, 2019a, 2019b), relational and communication outcomes (Intensive Interaction Institute, 2015) and understanding of child's development, strengths and difficulties (National Portage Association, 2024).

The data suggests that WMP support can facilitate important and valuable outcomes for both child and caregiver through child-led play. Writers assert the value of child-led play, not simply for children's learning and development but more fundamentally as inherently pleasurable and meaningful (Music, 2016; Panksepp, 2007). The experience of play and mutual enjoyment allows for closeness and attachment to grow (Wakelyn, 2019a). Child-led play can be facilitated through supporting caregivers' close attunement to their child's experience. It is through child-led play, with caregiver's individual attention, that moments of intimacy, vital for development, relationships and mental health, can occur (Hardy et al., 2015; Meakings & Selwyn, 2016; Wakelyn, 2019b).

Caregivers spoke about how valuable it had been that WMP provided children with choice. They recognised that when their child began to make choices in play they could know more about their child's likes and dislikes rather than feeling they had to be directive. Hearing participants discuss how valuable it had been for them to see

their child make choices in play indicates that WMP was a positive experience for both child and caregiver, providing the child a sense of agency and self-esteem and giving the caregiver hope that development was taking place (Ye et al., 2024).

4.1.3 WMP can bring something new

WMP was described as bringing new insights to professionals, and for caregivers bringing the possibility of something new by offering more than they expected. In the data caregivers shared deeper, more fundamental changes in the way they interacted with their child since engaging in WMP.

Wakelyn (2025) wrote about moments of surprise as an important element of WMP. Ye and colleagues (2024) recognised that aspects of discovery, in approaches with young children, were indicative of development. Both writers explained this is linked with an emerging sense of agency for the child who can now try something new. For caregivers this can lead to increased confidence in their own agency; they can see their presence as vital to their child's development and emotional wellbeing which they may not have felt before, when caring for their child in care with emerging ND (Houzel, 1999; Rhode, 2007; Rhode et al., 2012). This element of bringing something new adds to mutual enjoyment and can be a motivating factor for caregivers and children to continue the approach. This was evident in the data, with a caregiver describing a fundamental change in the way she interacted with her child and in relation to section 4.4.2.1 – 'positive experiences for caregivers' where all participants described continuing with WMP after the sessions ended.

4.2 Theme Two – Potential Benefits of WMP

4.2.1 For the child

4.2.1.1 Positive experiences for the child

Participants recognised that WMP was enjoyable for their child and that their child felt more understood, more supported by, and more connected with their caregiver. One social worker hypothesised that the child “felt more understood” (PF2/P13/L19) and another social worker recognised that the child “enjoyed the sessions” (PF3/P7/L8). Wakelyn (2019a) described through observational vignettes how play became more enjoyable for both child and caregiver and hypothesised that it is mutual enjoyment through play that allows closeness and attachment to grow. This is an expected outcome which is well documented in other WMP literature (Wakelyn, 2019b; Wakelyn, 2019c; Wakelyn, 2025; Koenig et al., submitted for publication). Other approaches also recognise the importance of this, for example, II which aims to enhance mutual enjoyment through increased shared attention (Intensive Interaction Institute, 2015).

4.2.1.2 WMP promotes child-led play by providing individual attention

Participants recognised that WMP promoted child-led play by providing individual caregiver attention, which was particularly valuable for this cohort, and that this close attention supported relationship building. Several approaches, including WMP, attest the value of close caregiver attention to increase children’s free play through facilitating moments of attunement and caregiver responsivity (Kennedy, 2011; Lojkasek, 2025; Wakelyn, 2019b). Wakelyn (2019b) explains how by offering warm

and genuine interest, and attention to a child's free play, caregivers can become more attuned, experience mutual delight, create feelings of safety and enhance opportunities for exploration and playfulness. This is especially important for caregivers of this cohort whose play can be fleeting, which can make it more challenging for child and caregiver to experience mutual delight. Child development research explains that such experiences are vital for development, relationships and mental health (Hardy et al., 2015; Meakings & Selwyn, 2016; Wakelyn, 2019b).

Two caregivers discussed how WMP made their child feel more connected to them and described their children experiencing a new and different quality of caregiver attention. By providing this, caregivers appeared freed up to be less directive. This created positive feelings for children who were reportedly more able to feel and value the interest, attention and moments of attunement and intimacy.

A caregiver explained her child benefited from the close attention in WMP and began to make his own choices in play. She described how this enhanced the caregiver-child relationship because she knew her child on a deeper level, recognising that "might have been his favourite thing because he was actually choosing them himself" (CG3/P24/L29). Meins and colleagues (2013) explored the relationship between caregiver mind-mindedness and symbolic pretend play in children. They found that as caregivers became more able to see their child as separate from them, and with their own mind about which the caregiver can talk to them, the child's symbolic pretend play increased. Similarly, in the data, this participant is describing feeling more in touch with her child's mind during his free play which is likely to facilitate more free play for the child and in turn enhance their relationship.

4.2.1.3 WMP meets the needs of children with emerging neurodivergent development

Findings from the data highlighted specific features of WMP that meet the needs of the cohort. A professional noticed WMP was inclusive and recognised the child “felt very included” (PF2/P18/L8-26) by this, and because WMP was “a model which accepts … neurodiversity, and … complexity” (PF2/P10/L31) this made it accessible to children with emerging ND. Other approaches for children with emerging ND value the importance of inclusivity, for example, II which adopts a fully child-led approach to interaction and relationship building.

II also recognises how important it is for this group of children to be supported by an environment that feels safe and predictable to enable the child to engage with the approach. Two caregivers commented on how WMP was reliable and could support children to engage because it felt safe and predictable. This had been valuable for the children in their care. One explained: “he knew that it [WMP] was gonna happen again afterwards” (CG3/P32/L3) which helped WMP to feel like a reliable experience and supported her child to engage in the approach and tolerate the ending more easily. Another shared that: “the biggest benefit I think for [my child] was it was in his house” (CG2/P17/L21) which made it possible for her child to take part in WMP. This was unlike other interventions which their child had not been able to tolerate because they were outside of the child’s safe environment and were busy and unpredictable.

4.2.1.4 WMP supports children facing transitions

The data highlighted how during care planning, around children's transitions between foster care and adoption, there are times when foster carers do not feel heard and times when children's individual needs can be overlooked. Wakelyn (2012) articulated a common challenge for foster carers at times of transition when trying to advocate for the emotional and psychological needs of their child. WMP was described as bringing the child's emotional and psychological needs to the forefront by recognising the child's need for continuity and familiarity.

In the data, thoughts were shared around what is important for children during times of transition; one social worker explained that direct interventions tend to be avoided. It is understandable that professionals think carefully about introducing new professionals to a child who will be expected to say goodbye to important adults and build new relationships. However, the data demonstrated that WMP throughout transition provided significant benefits, and professionals felt relief, knowing that some continuity of support was available.

Many writers strongly advocate that transitions should be gradual (Browning, 2015; Lewis, 2018) and focused on building strong new relationships whilst retaining some continuity in existing relationships (Beek et al., 2021; Boswell & Cudmore, 2014). For this to be possible, child-focused care planning (Wakelyn, 2019a) and a well-functioning professional network (Browning, 2015) are vital. Child-focused care-planning requires the child's needs and feelings to be responded to sensitively, held in mind, and central to plans and timescales (Beek et al., 2021). The data demonstrated how WMP can contribute to child-focused planning and a well-functioning professional network by relieving some of the professional's anxiety –

highlighted in the use of the word “desperately” (PF1/P16/L18) by one social worker. Furthermore, WMP supported caregivers and professionals to think about what could support the child during the transition, for example, continuity and familiarity in their approach to thinking about his play and emotional world.

4.2.2 For the caregivers

4.2.2.1 Positive experiences for the caregiver

Psychoanalytic clinicians and writers describe many challenges for caregivers of this cohort to break free of a sense of inadequacy and failure and develop a sense of agency that they can get to know their child, understand them and make a difference to them (Houzel, 1999). In the data, caregivers shared that they learnt a new way of being with their child which extended to other aspects of life, giving them confidence to try new things and feel a sense of agency in supporting their child. This talking together after the WMP session promotes mentalization and develops caregivers’ capacity to reflect on their own experience and their child’s experience (Fonagy, 2002; Meins et al., 2013). The experience of talking and thinking in this way supported one caregiver to develop a sense of agency which allowed her to think flexibly about what she could do differently to support her child and improve aspects of family life for them all.

One caregiver described feelings of isolation related to caring for a young child in care with emerging ND. The same caregiver explained WMP provided her with an experience of having the WMP practitioner alongside her and her child, spending time with them, and she felt “it’s nice to have somebody else come in and see a bit of what

I see" (CG4/P13/L18). Wakelyn (2019) describes that, being alongside caregivers and facilitating child-led play, is one of the distinct aspects of WMP that is different to other approaches for young children that promote child-led play through teaching about its importance. Other writers report that when caregivers feel more contained they begin to trust their own knowledge about their child and notice their child's new achievements (Ye et al., 2024). WMP practitioners join caregivers with their child, to learn together about how to encourage child-led play; something some caregivers can find new and challenging.

All the caregivers in the study described how they continued with WMP after the sessions came to an end. In a report exploring the state of early intervention, authors describe how, when thinking about effective early intervention, it is important that approaches focus on social and emotional development (Casebourne, 2018) and occur within supportive relationships (RFCEC, 2021). The fact that each of these caregivers continued with WMP after the sessions finished, indicates that caregivers internalised the benefits of WMP for the child, the caregiver and the relationship. It could be hypothesised that for caregivers, internalising the WMP approach, could lead to longer lasting and sustained changes that can improve attachment security and emotional quality within the relationship (Barlow et al., 2016). In turn this could reduce the incidence of mental health problems for young children in care (Casebourne, 2018). Wakelyn (2025) suggests that it may have been the element of discovery and seeing new development that WMP gave caregivers the confidence and motivation to carry on.

4.2.2.2 Focus on attuning to and understanding the child through undivided adult attention

According to authors who have written about approaches with young children, there is a shared consensus that many approaches with this cohort aim to notice and promote moments of attunement, caregiver sensitivity through observation, close attention and child-led play (Kennedy, 2011; Lojkasek, 2025; Wakelyn, 2019b). Participants commented on the function of attention in WMP and recognised that focused attention upon the child's play could act as "a kind of way in" (PF2/P19/L26) supporting the child to feel accepted and more deeply understood. This is echoed in the WMP literature by Wakelyn who (2019a) describes how by providing close attention, the child feels held in mind and the caregiver develops a deeper and more meaningful sense of their child's interests, dislikes, strengths and difficulties. This is beneficial for both child and caregiver who, through attending to their child's free play, can become more attuned, and experience mutual delight, which creates feelings of safety and enhances opportunities for exploration and playfulness (Wakelyn, 2019b).

In the data, caregivers recognised this as part of the approach and that attention is vital to all young children, one caregiver said, "they just need your undivided attention" (CG3/P38/L21). WMP recognises the vital and protective nature of close attention, which is especially important for children in care who are more likely to have lacked attuned care and find it more difficult to relate, communicate and learn in later childhood (Schore, 2001; Wakelyn, 2019b).

In the data it was recognised that close attention is particularly valuable for young children in this cohort, whose play, development and emotional world can be difficult for caregivers to understand. Wakelyn (2019a) recognises that caregivers of this

cohort can find attending to their child's play closely and thinking about their development (Rhode & Grayson, 2018) more difficult. One caregiver described developing a better understanding of the different ways her child attempted to gain attention and what this might mean for his emotional state and his developmental capacity, for example, "that sort of attention seeking is him not feeling very good and not very comfortable rather than not being able to play on his own" (CG1/P14/L24). One aspect of this comment demonstrates how this caregiver notices that, rather than considering 'attention seeking' as an unwanted behaviour, as it is sometimes framed, instead she understands his need for attention as something vital to his emotional world and development. This also highlights the caregiver's own development of a more nuanced understanding of why her child might 'not be able to play on his own'. This is often discussed when thinking about this cohort. For this caregiver, there is a new understanding that, rather than being a deficit in her child's capacity, the child's struggle to play on his own is understood as a communication about his relationships and emotional world.

4.2.2.3 A different way of being with the child

A further benefit of WMP for caregivers is how WMP offered a different way of being with their child, becoming less directive. One study found that caregivers of infants at high risk of developing autism were more directive in interactions with their child and less sensitively responsive (Rhode & Grayson, 2018; Wan et al., 2013). It is likely that the WMP approach, with in vivo comments serving as immediate feedback for the caregiver, supported caregivers to be with their child in a different way. Many writers researching effectiveness of interventions with young children and caregivers, suggest

in vivo coaching was most effective in shaping parental behaviour (Barnett et al., 2014; Barnett et al., 2017; Heymann et al., 2022). Shanley & Niec (2010) proposed this method of providing guidance as one of the active ingredients or catalysts for change in evidence-based caregiver-child programmes.

One caregiver described how WMP encouraged her to be more self-reflective. Through close observation, attention and reflecting together afterwards, WMP supports caregivers to experience emotional containment, promote mentalizing and develop a capacity to reflect on their own experience as well as their child's, which supported this caregiver to find different ways of being with her child that could be sustained.

4.2.2.4 Supporting caregivers to meet the needs of children in care

Wakelyn (2012) comments that caregivers of children in care require support because they are navigating a complex task, in caring for vulnerable, often traumatised young children. Participants in this study described how WMP provided them with support to be with, and meet the needs of, their child in care. For example, one caregiver said: "We would have been lost without [WMP]" (CG3/P49/L4). Another explained that WMP helped them provide the important play and understanding their child needed.

It can be disturbing and distressing for caregivers to connect with the child in their care's emotional world. One caregiver talked about their child's emotional experience of transition from foster care to adoption. Wakelyn (2011) describes how the observational stance of WMP can be especially helpful for young children in care because the observer can provide containment for the dyad, encourage attuned and

sensitive interactions between child and caregiver, and modulate experiences of separation (Rhode et al., 2012).

One caregiver explained WMP was helpful in supporting her and her child to manage closeness, separations and relationship building – “getting him to be happier around [his adoptive father]” (CG1/P57/L21) and manage separation “having something that was separate to me as well” (CG1/P51/L19). It could be hypothesised that by making dedicated quality time together in WMP, moments of separation could gradually feel more tolerable. Child development research reports that young children in care often face significant challenges in developing a coherent sense of self and a capacity to form relationships and tolerate separations. For these children, being seen with attuned curiosity, as can be provided by WMP, can be a powerful experience that can support development and the emerging sense of self (Bowlby, 1969; Fonagy, 2002; Siegel, 1999; Winnicott, 1971).

4.2.3 For the child-caregiver relationship

4.2.3.1 Quality time

Participants talked about how WMP encouraged them to prioritise quality time together with their child which enhanced their relationship. It is likely that the structure and predictability offered by WMP, alongside the company, observational stance and attention provided by the WMP practitioner, supported caregivers to manage the experience of being with their child as they played. One study found that, to have the most influence on parenting, interventions needed to focus on younger children, and work with caregivers to increase ‘protective factors’ associated with resilience

(Evangelou et al., 2007), such as, increasing experiences of quality time together and enhancing relationship building.

4.2.3.2 Relationship building

Participants shared how by watching the child's play, caregivers developed empathy and found ways to connect with their child. One caregiver described how WMP "gave us an understanding of what he was going through" (CG3/P49/L5) and a social worker talked about caregivers "trying to be on the same wavelength" (PF2/P4/L1) as their child during WMP. This was described as supporting relationship building, for example, the WMP "was just getting him a bit more bonded with [his adoptive father]" (CG1/P57/L19). I found compelling evidence that suggests that supporting relationships between caregivers and their young children is of primary importance and can be an effective early intervention strategy to promote learning (Evangelou et al., 2007). RFCEC (2021) recognised that healthy development requires nurturing relationships, environments and experiences. Barlow and colleagues (2016) found that interventions that support caregiver-child relationships early in life can improve infant attachment security and emotional quality within the relationship.

Participants shared how WMP supported them to develop a deeper understanding of their child's emotional world, strengths and difficulties which helped them unpick complex developmental and relational difficulties; one caregiver reflected on her child's struggles with activities ending and with daily routines, especially mealtimes, and reported that through WMP they had found playful and creative ways to support him with this.

4.2.4 For the professional network

4.2.4.1 Positive experiences for the professional network

Professionals shared several positive experiences of WMP for the professional network. These included a social worker who reflected on a surprisingly successful outcome for a child. Wakelyn (2019a) found that WMP could support the professional network to create a more coherent picture of the child's emotional world, which facilitated child-focused planning and provided the voice of the child. A social worker described how WMP can help professionals pay attention to the child's needs and experiences during a transition in order to make plans for meeting adoptive parents "at the child's pace" (PF2/P30/L5), "in places the child felt comfortable" (PF2/P30/L5) and using "transitional objects" (PF2/P30/L5).

Another benefit for the professional network was "the team around the child approach" (PF2/P32/L1). Social workers valued WMP review meetings with the professional network. This is a significant finding that strengthens the argument for robust multi-disciplinary working when offering WMP with this cohort. Wakelyn (2019c) emphasizes the importance of maintaining regular communication with professional networks. The Best Start for Life report explains that services need a well-functioning, coordinated and multi-disciplinary approach to supporting families with young children (Leadsom et al., 2021); Robinson and Midgley advocate for strong working relationships between allied professionals which can be fostered through "mutual respect of professional roles and responsibilities" (2024, p. 68).

4.2.4.2 Better understanding of the child

An aim of WMP is to contribute to professionals becoming more in touch with the infant's emotional reality, especially children in care (Wakelyn, 2011). In the study, professionals reported that WMP work helped them to develop a deeper understanding of the child, one participant put it, by creating "a little … window" (PF2/P19/L8) into his world. This was described as helping build relationships, between a hard to reach, vulnerable child, and his caregiver and professional network. The social worker explained how he had worried that he would not be able to find a way to connect with him: "how are we going to engage with him because he pushes people away?" (PF2/P19/L8). The same social worker reflected, movingly, that the WMP work made him feel that "some of these children that we perhaps worry are lost can actually be retrieved" (PF2/P32/L8) because WMP provided the child with a means of connection and allowed the child to be more deeply understood.

A social worker recognised that WMP developed their understanding of the child's emotional world because all involved, could see the child "through the same lens" (PF1/P16/L17). Writers on transitions for children in care concur that these moves have the potential to perpetuate painful feelings associated with earlier losses and may contribute to further relational trauma (Browning, 2015; Lanyado & Caldwell, 2002; Wakelyn, 2011). They may also offer children in care a new and different experience of separation, in which painful feelings can be recognised, processed and mourned (Browning, 2015). WMP supports professional networks and caregivers to develop a deeper, shared, understanding of the child's emotional world which can engender hopefulness and support a new experience of transition.

Professionals' deeper understanding of the child is especially important for this cohort. A social worker shared how WMP supported a clearer understanding of the child's development and behaviours. He shared how being alongside the child and their caregiver, when behaviour was confusing and disturbing and development was not linear, can take "a psychological toll" (PF2/P20/L10-31) and this can lead to professionals and caregivers losing hope. Wakelyn (2011) recognises how professionals are under enormous pressure and navigating overwhelming feelings of loss and rupture that are stirred up by the infant's experiences. This can make it challenging to persist and to hold out hope. Nevertheless, WMP has been shown to support caregivers and professionals by being present with them in their experience with their child (Wakelyn, 2019a) and it could be hypothesised that this increases hopefulness for professional networks which can bolster resilience.

4.3 Theme Three – Challenges and Difficulties

4.3.1 For the caregivers

4.3.1.1 Doing things differently

Caregivers found that WMP was more difficult for them than for their child. The challenges, in part, appeared to be about recognising that WMP required caregivers to do something differently. For example, one caregiver explained that they "do play with him anyway" (CG2/P11/L21). Wakelyn's (2019a) writing illuminates this challenge, describing how foster carer training may not emphasise the importance of individual attention, interaction and play for young children with their caregivers at home. This might hinder caregivers' recognition of these distinctive aspects of WMP.

Another caregiver reported that WMP was challenging because it asked her to be with her child in a different way. This was initially difficult to sustain. Other caregivers found it challenging to offer undivided attention which seemed related to the child's play being "so limited" (CG4/P16/L1). These challenges for caregivers appeared to be related both to their child's care experience and emerging ND. Writers interested in approaches to support infants at high risk of developing autism found that caregivers were more directive in interactions and less sensitively responsive (Rhode & Grayson, 2018; Wan et al., 2013). This was illustrated in the data: one caregiver shared that she worried about whether her child could play, learn, and develop and noticed that these worries led to her becoming more adult-led and directive in play with her child.

It is not uncommon for caregivers of young children to feel worried about their child. Studies indicate that 42% of parents worried about their young child's social or emotional wellbeing or behaviour (O'Meara et al., 2022), 75% of parents worried about their young child's mental health and 67% worried about their development (NSPCC, 2024). Due to the compounded difficulties faced by this cohort; figures for caregivers of these children may be higher. Being directive with their child is likely to leave caregivers feeling they are doing something, which can increase their sense of agency. However, this reduces the child's opportunity of engaging in child-led play. Through engaging in WMP, one caregiver found she was able to see her child was developing which supported her to watch his play and be less directive.

4.3.1.2 Timeliness of WMP

In the data, caregivers expressed disappointment WMP had not been offered earlier. A foster carer imagined more benefits if they had received WMP sooner, especially

when caring for a child with emerging ND for the first time. A recent NHS report stated that evidence-based early intervention is recommended as soon as possible after developmental differences indicative of autism are identified (Green et al., 2022). Since there are much higher rates of ND in cared-for children, effective early intervention is especially important.

Despite the desire for WMP as early as possible, caregivers shared a further challenge, that it took time for WMP to make sense and some caregivers felt unsure about whether WMP could help. For caregivers experiencing the compounded challenges inherent in caring for a child in care with emerging ND, it is understandable that hopefulness around available support might, at times, be limited. Wakelyn (2019a) explains that WMP can provide support and company for caregivers in their experience with their child. It could be hypothesised that this may increase hopefulness for caregivers.

On introducing WMP, it was important to develop a shared understanding about the aims thereof. Wakelyn (2019c) describes the importance of maintaining communication with professional networks and caregivers to enhance effectiveness and influence change.

4.3.1.3 Time investment

Caregivers shared that time was needed for WMP. One caregiver explained “it takes time” (CG3/P4/L1) and another talked about the need for “practice”, because WMP does not necessarily come as “second nature” (CG1/P56/L12). This challenge seemed especially relevant for this cohort because child-led play can be limited and challenging to sit with. Caregivers can find themselves being more directive due to

concerns about their child's development and because of how painful it can be to connect with their child's emotional world (Rhode & Grayson, 2018; Wakelyn, 2019c). Furthermore, WMP asks caregivers to do something differently, as discussed in section 4.5.1.1, which can take time.

One caregiver explained that WMP did not help with "the most critical things at the time" (CG1/P92/L21-29). It could be that more time was needed, or a further intervention would have been helpful to support the child and his caregivers alongside or after WMP. This reiterates the importance of setting up WMP in a way that the main concerns are recognised from the outset and aims are agreed, with a shared understanding between caregivers and professionals. Further, regular reviews should be held to identify whether more, or different, support is needed (Leadsom et al., 2021; Wakelyn, 2019c).

4.3.2 For the child-caregiver relationship

4.3.2.1 Being together

Caregivers shared challenges of being together with, and attending to, their child in care's play and described how this felt different to being with their own children while they played. In part this illuminated the anxiety and painfulness stirred up by attending to children in care's play. What also emerged is that play can be considered less important for this cohort of children, despite their vulnerability, as highlighted by authors writing about children in care: children in care are at much higher risk of mental health difficulties in childhood and later life, and their capacity to form secure attachments is profoundly compromised (Lauritsen, 1993; Wakelyn, 2012). It could be

that giving undivided attention to the play of children in care is more difficult. WMP can support caregivers to navigate this and help caregivers to attune their child's need for attention. Wakelyn (2019a) describes this kind of shift for Molly's foster carer who became more able to attune to her distress and long periods of crying reduced.

4.3.3 For the professional network

4.3.3.1 Understanding what the approach involves

The findings highlighted a professional trepidation about child-led play. Literature helps to illuminate the challenges around anxiety that child-led play could increase the sense of chaos. There are complex emotional dynamics at play for professionals supporting young children in care and their caregivers. These dynamics can lead to individual burnout and impact on professionals' capacity to be reflective and recognise their own emotional experience and needs, and those of the children they are supporting (Obholzer & Roberts, 2019). Furthermore, Wakelyn (2019a) recognised a gap in training for foster carers around the importance of individual attention and child-led play. This social worker's comment could imply a similar gap in training for social workers.

Professionals worried about WMP being recommended as 'relationship building' for children and foster carers, especially if this suggestion was felt to be a judgement of something lacking. It appeared 'relationship building' raised anxiety, when thought about in relation to children in care. This is despite the understanding that children in care are more in need of quality, stable relationships due to the abuse and neglect they are likely to have experienced and the lack of quality attuned care (Schore, 2001;

Wakelyn, 2019b). Therefore, even experienced, loving and dedicated foster carers may need support with relationship building because these children have complex emotional and developmental needs. Nevertheless, providing support that helps with relationship building can feel concerning for foster carers who may feel a huge pressure to be better than ‘good enough’ especially before a child is moving on to adoption. Professionals felt a similar anxiety about this kind of support, as if it could threaten or undermine the adoption process. Professional networks need support to continue thinking reflectively, especially when anxiety is high (Bevington et al., 2017; Wakelyn, 2019c). Wakelyn (2019c) suggested a focus on experiences, interactions, and play could support professionals to remain attentive to the child's emotional reality; thus, WMP can help professional networks come together and develop reflective thinking (Bevington & Dangerfield, 2024; Bion, 1962a).

4.3.3.2 Involvement

The data demonstrated that at times professionals did not feel fully invested in WMP. Wakelyn (2019a) noticed that child-led play is not often prioritised in foster care training and instead the focus is on behaviour management, maintaining routines and creating protection and safety, which however important, risks missing fundamental opportunities to facilitate children's play. This potential lack of professional involvement in WMP seemed to risk professionals not being able to notice the impact of WMP on the child and caregiver. This emphasises the importance of involving the professional network when offering WMP.

Conclusion

5.1 Summary of the findings

This small-scale study aimed to find out about the experience of WMP for caregivers of young children in care with emerging ND, the challenges that WMP might present for caregivers of young children in care with emerging ND and the contribution of WMP, if any, to the work of the professional network for young children in care with emerging ND.

Caregivers experience of WMP was varied but shared common themes, including several benefits of the approach with this cohort of children and their caregivers. Findings indicated that WMP support has the potential to increase child-led play and increase caregiver attention to the child, even when the child's play was felt to be difficult to stay with.

Some specific challenges were discussed. Caregivers reflected on becoming more directive because of concerns about the child's development and awareness of their child's traumatic history. Some participants were able to recognise that a more child-led stance was helpful for development and relationship building.

WMP was reported to enhance caregiver-child relationships for dyads in this study. An interesting finding was that social workers shared reluctance around introducing WMP as an approach for relationship building. There was a concern that this might undermine foster carers by implying criticism of the caregiver-child relationship.

Some contributions to the work of the professional network were expressed, in the context of this small-scale study. Caregivers and professionals reported feeling more confident about understanding the child and this informed child-centred care planning.

All of the participants shared that they experienced benefits of WMP throughout transitions for children, in relation to experience of caring for a child in care with emerging ND.

The findings also highlighted the importance of providing timely support and of establishing a shared understanding about the rationale for providing WMP support at the beginning of any intervention. This study suggests that reviews of WMP support with the professional network can help to develop and sustain shared understanding of the child and enhance decision-making by professional networks.

5.2 Reflections from a psychoanalytic perspective

I completed this study as part of the doctoral research element of my training as a Child and Adolescent Psychoanalytic Psychotherapist (CAPPt). I felt that this training enhanced my capacity to engage with the WMP approach. The close attention to observation, and relational and unconscious dynamics – as core elements of the CAPPt training – put me in a good position to provide WMP with model fidelity. Nonetheless, being immersed in working within the transference in once weekly and intensive Child and Adolescent Psychoanalytic Psychotherapy during the CAPPt training, I found myself wanting to think at a similar depth during the interviews with participants and this was not needed to address my research aims. This left me feeling unsettled and de-skilled at times.

I chose to engage with data collection and data analysis with a pragmatic approach, rather than applying an in-depth psychoanalytic framework, because I wanted to understand each of the participants' individual experience of WMP and I was not seeking to look beneath the surface at the unconscious relational dynamics. In some

ways I felt conflicted about this and worried this would be less satisfying as a researcher and CAPPt in training. Nonetheless, I recognised that a pragmatic approach was firstly, more achievable with time and capacity demands, and secondly, better suited to the aims of my research which prioritised capturing participants' accounts of their experiences. This approach contributed to the strengths of the study, in so far as, the study was achievable to complete alongside a demanding clinical training, and the study captured participants' accounts of their experiences. This approach also contributed to some limitations, as described below.

5.3 Limitations of the study

I set out to complete this study because of an existing interest in the WMP approach, particularly with this cohort of children. My interest in the approach was likely recognised by participants, given my choice of research topic and my position as a clinician who values this way of working. As a result, my perspective might have influenced the data collection and analysis and contributed to potential researcher bias.

The sample of participants (caregivers) who took part could have further contributed to this bias. I was mindful that the families I work with in the under-fives mental health service have vulnerabilities and, for ethical reasons, I chose participants (caregivers) who I believed were in a position to manage an interview. This therefore shaped the sample. The caregivers I interviewed were all well-resourced, with good support from family and professionals and they were all interested in their child's emotional life. This sample may have influenced the data in terms of their capacity to make use of an approach such as WMP.

This study succeeded in gathering rich data from a small sample. But the small size of the sample (seven participants) is a limitation. Another limitation is that all the participants were supported by the same practitioner in the same service.

My lack of experience conducting semi-structured interviews was a limitation. This resulted in data, from significant chunks of conversation, which could not be analysed as it was not relevant to the research questions. On reflection, I recognised that my difficulties in conducting the interviews was not only due to a lack of experience but also influenced by me inhabiting multiple roles in relation to the participants (clinician, researcher, colleague). This feels especially relevant when reflecting on my experience of interviewing caregivers. I explained to participants that I was thinking with them as 'researcher' and I understood that they also knew me as 'clinician'. Despite being explicit about this, caregivers wanted to share with me about their child's progress and struggles since our last contact and I could not help but be pulled into this way of relating with them – because of my interest in their child and family, my wish to continue to support them, and my gratitude for their participation in the study. This was especially noticeable with caregivers that I had not been in contact with for some time prior to the interview.

In preparation for my viva, I noticed something in the data that caught my attention in a new way. One caregiver described prioritising time together with her foster child, free from disturbance (see findings: CG3/P38/L3). During this interview, the data analysis and when writing the final thesis, I had understood this comment at face value as a communication about prioritising quality time together with her child, without interruption. On reflection, and with some distance from the study and the work with this family, I could see a possible deeper meaning related to the choice of word – 'disturbance'. I wondered about this caregiver sharing, at a deeper level, a

communication related to what it can be like for her, being with a young child in care with emerging ND during play. Could it be that she was expressing that this can be disturbing and can bring about disturbance? Perhaps it was too painful for me, when in close contact with this family and the data, to truly hear and see what was possibly being communicated at this deeper level? Furthermore, the way I chose to engage with RTA as a methodological approach may have somewhat disguised this because I did not focus on the latent unconscious meanings of the data.

5.3 Strengths of the study

My position as researcher, interviewer and clinician had potential to provide strength and/or limitations. My hope is that through focused researcher reflexivity these multiple positions add richness and value.

The focus on a group of children who are underrepresented in research is a strength of the study. One of the children thought about in this research was supported by WMP during transition from foster care to adoption and this became a relevant and interesting aspect of the data. Children in care and facing transition are a vulnerable population who are rarely represented in research. Exploring this experience with this population is a further strength of the study.

Another strength is that the study has generated implications for practice that have the potential to enhance caregivers' experience of WMP; strengthen professional relationships and effectiveness when providing WMP with this cohort; and potentially increase awareness of WMP amongst foster carers, adoptive parents and social workers so that more children have timely access to this approach.

All participants (including some caregivers who had not received WMP for up to 14 months at the time of interview and professionals who had not been directly involved in delivering WMP and had similarly experienced a significant gap between the time WMP was provided and the time of the interview) could vividly describe specific aspects of the intervention, the child's individual play interests, and the child's development over time. This is not insignificant and can be understood as confirmation of a deep engagement made by participants in the approach, and the deep impact WMP has had on them, for some, lasting many months. This indicates that the WMP approach, with this cohort of children their caregivers and professional networks, can contribute to long lasting and meaningful development.

5.4 Recommendations for practice

This study was based on a small sample and yet it has led to significant and meaningful recommendations for practice. I created a full table of implications (Appendix J), and a concise table is included below.

Implications for Practice
In general: o Important that the aims of WMP are clear. o Caregivers appreciate WMP that can be long-term. o Some foster carers and adoptive parents would like WMP training course. o Sharing observations and reflections from WMP with the professional network is needed so professionals understand the approach and feel involved. o Effective WMP requires a professional network team approach. **For children with emerging ND and their caregivers:** o Caregivers of children with additional needs and/or emerging ND require bespoke support as soon as possible.

- WMP training courses would benefit all foster carers, particularly if they are newly caring for a child with emerging ND.

For children in care, their caregivers and professional networks:

- WMP is most impactful at the beginning of relationships.
- WMP can be used with foster carers, adoptive parents, family members or new foster carers to support transitions.

Before implementing WMP it is important to establish shared goals which need to be discussed and clearly articulated. These need to be shared with the professional network so that all involved are clear about the approach and aims for each family from the start.

When introducing WMP, it is important to consider caregivers' experience, skills, strengths, and concerns. The duration of support needs to be flexible, adjusted to the needs of the family, regularly reviewed and offered long-term where needed. The study showed that, for children in care with emerging ND, providing WMP that can start earlier and last longer is likely to be beneficial.

WMP training would be helpful for foster carers and adoptive parents, particularly those caring for a child with emerging ND.

Regular reviews are valuable opportunities for professional networks to discuss progress and to think about the child's play, development, behaviour and emotional world.

Dissemination of WMP among professionals is needed system wide.

WMP can helpfully bridge transitions between placements and support children and caregivers to be more in touch with the loss inherent in transitions as well as excitement and hope for the future.

5.5 Recommendations for research

From engaging with literature and interrogating the data, several potentially rich areas of future research emerged.

To explore these same research questions with a larger sample size and when WMP has been offered by different teams and practitioners to enable deeper exploration of these themes as specific to this study, or more widely associated with WMP with this cohort.

To focus on WMP with children with emerging ND and/or autism. This was my initial aim and other WMP researchers share this interest.

To investigate the experience, and challenges, of child-led play with young children with emerging ND as I found no research with this focus.

To explore children's, caregivers' and professionals' experience of WMP during transition between foster care and adoption. There will be significant ethical considerations to a study of this kind because of the vulnerability of this population, at this time.

To better understand the experience of WMP training for foster carers, adoptive parents and social workers.

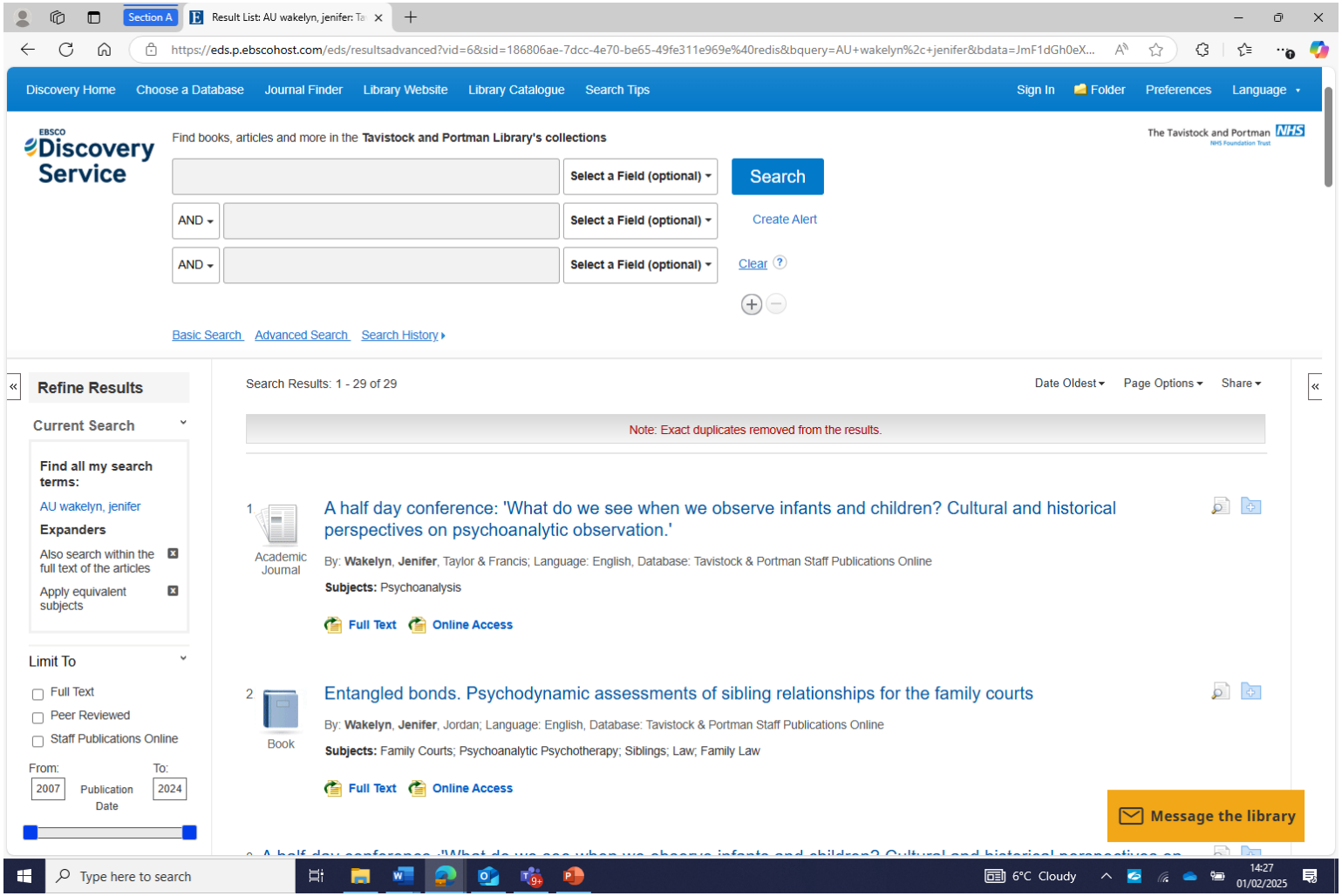
Appendices

Appendix A – Local support services

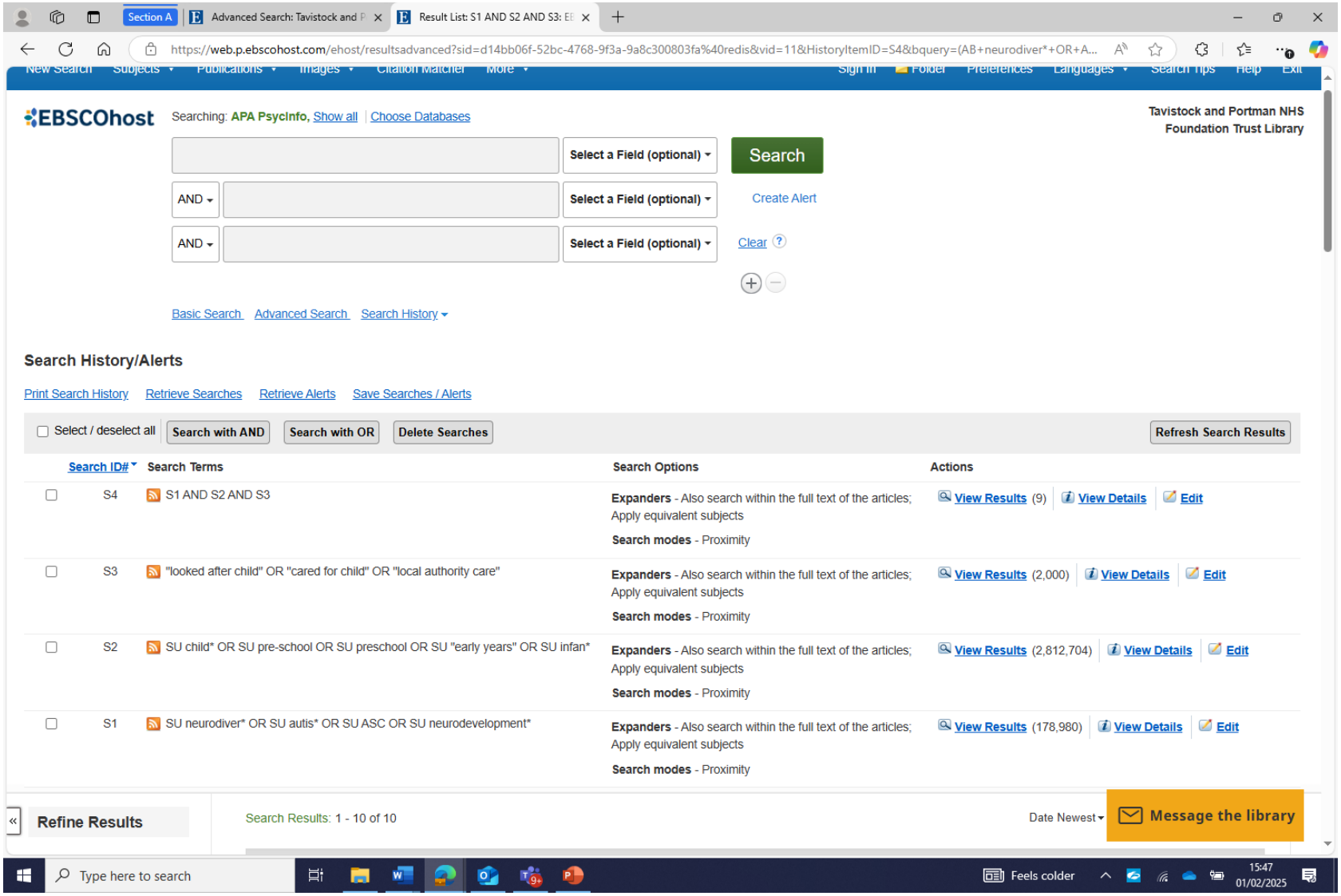
Specialist Outreach Support Service	Education-based outreach team that provides support to early years settings experiencing challenges in meeting the developmental and educational needs of children. The team conducts observations and offers evidence-based strategies, often behavioural, to enhance inclusive practice and individualised support.
Early Help	Voluntary, non-statutory family support approach embedded within Family Intervention and Social Care teams. The Early Help Assessment is a collaborative process aimed at identifying and supporting vulnerable families, with regular reviews by professionals involved with the child, family, and educational setting.
Health Visiting	Team of health professionals who support the health, wellbeing and development of children under five and their families. Health Visitors have a key role in identifying when a young child might need extra support with their development. Health Visitors work closely with children, caregivers, education settings and other professionals to support all children to have the best start in life.
Family Hubs, Grow and Local Offer	There are four Family Hubs in the area where this research took place, each Family Hub acts as a 'one stop shop' offering early support to families to help overcome difficulties and build strong relationships. Grow is a collaborative initiative supporting children from antenatal to five, offering extensive online resources on child development, caregiving, early relationships, childcare, education, SEND support, and access to services. The Local Offer is a statutory, comprehensive guide detailing available support for children and young people (0–25 years) with SEND, including those with emerging ND.
Parenting Team	A multiagency parenting panel assess referrals and offer a wide variety of courses and support, in collaboration with other teams including PIMHS, Health Visiting and Midwifery, to parents and caregivers from antenatal to the child's fifth birthday. The courses offered include Solihull parenting courses.
Portage	A home-visiting educational service for preschool children with SEND who are not yet in an education setting. Portage workers support early development, help families access benefits, attend events and groups, and assist with transitions to nursery or school, while also reducing barriers faced by families of children with SEND.
Speech and Language Therapy	A health-based team, speech and language therapists work closely with caregivers, education settings and other professionals, to support children with communication needs to reach their communication potential and participate fully in all areas of life.

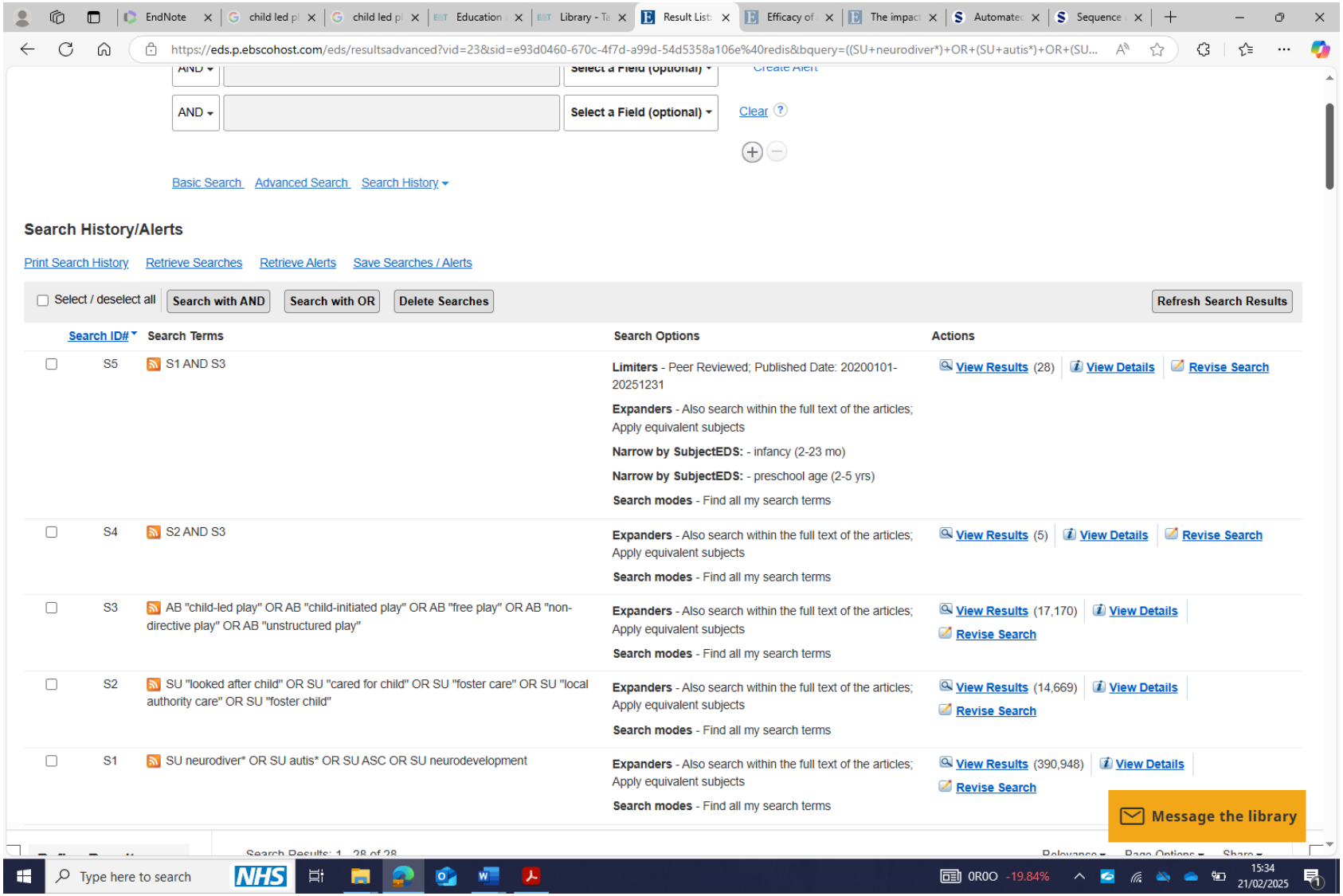
Home Start	A charity of volunteers who support parents and carers who are vulnerable and struggling with the difficult task of parenting. Home Start provides different offers of support, including one-to-one support at home and advice around early learning.
Our Kids Eyes	A parents support group run by parents who have lived experience of being parents to children with SEND.
SENDIASS	Free and impartial advice to parents and carers of children (0-25 years) with SEND.

Appendix B – Literature search for Wakelyn, Jenifer as author



Appendix C – Systematic search results

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Advanced Search
Search History
Search History/Alerts
Print Search History
Retrieve Searches
Retrieve Alerts
Save Searches / Alerts
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Search with OR
Delete Searches
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Search Options
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S5
S1 AND S3
Limiters - Peer Reviewed; Published Date: 20200101-20251231
Expanders - Also search within the full text of the articles; Apply equivalent subjects
Narrow by SubjectEDS: - infancy (2-23 mo)
Narrow by SubjectEDS: - preschool age (2-5 yrs)
Search modes - Find all my search terms
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Revise Search
S4
S2 AND S3
Expanders - Also search within the full text of the articles; Apply equivalent subjects
Search modes - Find all my search terms
View Results (5)
View Details
Revise Search
S3
AB "child-led play" OR AB "child-initiated play" OR AB "free play" OR AB "non-directive play" OR AB "unstructured play"
Expanders - Also search within the full text of the articles; Apply equivalent subjects
Search modes - Find all my search terms
View Results (17,170)
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S2
SU "looked after child" OR SU "cared for child" OR SU "foster care" OR SU "local authority care" OR SU "foster child"
Expanders - Also search within the full text of the articles; Apply equivalent subjects
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S1
SU neurodiver* OR SU autis* OR SU ASC OR SU neurodevelopment
Expanders - Also search within the full text of the articles; Apply equivalent subjects
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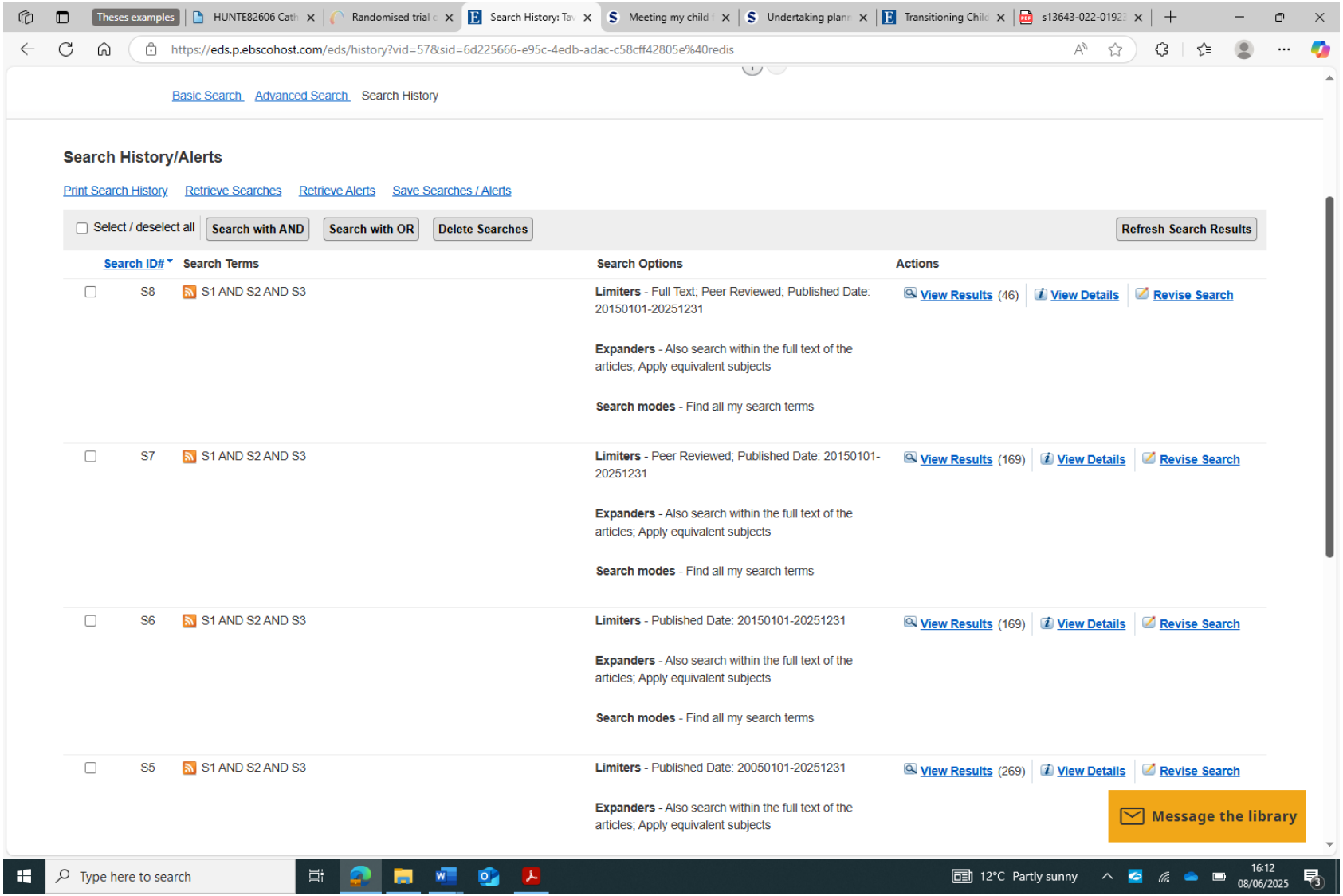
Theses examples
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Limiters - Published Date: 20050101-20251231
Expanders - Also search within the full text of the articles; Apply equivalent subjects
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08/06/2025

Appendix D – Ethical approval

The Tavistock and Portman NHS
NHS Foundation Trust

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

Tel: 020 8938 2699

https://tavistockandportman.nhs.uk/

Jessica Martin

By Email

5 April 2023

Dear Jessica,

Re: Trust Research Ethics Application

Title: 'What is the experience of 'Watch Me Play!' for the professional network and for caregivers of young children with emerging neurodiverse development who are supported by an Early Attachment Service?'

Thank you for submitting your updated Research Ethics documentation. I am pleased to inform you that subject to formal ratification by the Trust Research Ethics Committee your application has been approved. This means you can proceed with your research.

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

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

I am copying this communication to your supervisor.

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

Yours sincerely,

Academic Governance and Quality Officer
T: 020 938 2699
E: academicquality@tavi-port.nhs.uk

cc. Course Lead, Supervisor, Research Lead

Appendix E – Participant information sheet

Participant Information Sheet

Project title

What is the experience of 'Watch Me Play!' for the professional network and for caregivers of young children with emerging neurodiverse development who are supported by an Early Attachment Service?

Who is conducting this research project?

My name is Jess Martin, and I am a Child and Adolescent Psychotherapist in Clinical Training studying at the Northern School for Child and Adolescent Psychotherapy. I also work for Tameside and Glossop Early Attachment Service and Tameside and Glossop Child and Adolescent Mental Health Service (CAMHS). Both services are commissioned by Pennine Care NHS Foundation Trust.

This project is being sponsored and supported by The Northern School of Child and Adolescent Psychotherapy in collaboration with The Tavistock and Portman Centre which is overseen and certified by The University of Essex. All relevant ethical approval including Tavistock Research Ethics Committee (TREC) approval has been gained. I have designed the study and will conduct the interviews and data analysis.

What is the purpose of this study?

In this study I aim to find out about caregivers' and professional's experience of 'Watch Me Play!' with young children who have emerging neurodiverse development. 'Watch Me Play!' is a child-led, play-based therapeutic intervention which is used with young children and their caregivers

Through exploring caregivers' experience, I hope to find out about the way in which 'Watch Me Play!' might be used with children and families where the young child has emerging neurodiverse development, particularly when it is felt that this has had an impact upon the caregiver-child relationship. By exploring the experience of professionals, I aim to develop a deeper understanding about how 'Watch Me Play!' might serve to illuminate the needs, and lived experience, of the child for the network.

This project is an educational project which makes up the doctoral thesis element of my clinical training as a Child and Adolescent Psychotherapist.

What is 'Watch Me Play!'?

'Watch Me Play!' is a psychoanalytically informed therapeutic intervention originally designed for use with foster cares and young cared for children to support relationship building. However, in recent years 'Watch Me Play!' has been effectively used with a wider range of young children. 'Watch Me Play!' offers time for parents to attend with interest to their child

and begin to find out about their child's inner world through paying close attention to, and actively joining in with, their play.

For more information about this approach, visit:
www.tavistockandportman.nhs.uk/care-and-treatment/our-clinical-services/watch-me-play/

What do I mean by emerging neurodiverse development?

Neurodiversity is a term which is used to refer to a range of developmental differences in individuals. It can be used when thinking about developmental diagnoses such as Autism Spectrum Condition (ASC) or Attention Deficit Hyperactivity Disorder (ADHD), among others.

The term neurodiversity is also used when thinking about emerging differences in young children's development before any formal diagnosis has been sought. These differences may have been noticed early on in a young child's life or may be coming to the forefront as the child grows and develops, moving on to new developmental stages such as weaning, using first words, or starting nursery.

What will taking part in the study involve?

You will be asked to take part in one interview which will last no more than an hour. This can take place in person at a convenient clinic location or virtually over MS Teams. The interview will be semi-structured which means I will ask some questions as prompts, but it will mostly be an opportunity for you to speak freely about the experience of 'Watch Me Play!' I will audio record and transcribe each interview.

Taking part in the project will have no bearing on the outcome of any further assessments your child may be waiting for and it will not impact any other treatment that you receive from the Early Attachment Service or CAMHS. I will meet with you before the interview so I can answer any questions you might have before we begin.

Who can take part in the study?

All participants will be caregivers of children who have emerging neurodiverse development and who are 0 – 5 years of age, or professionals from their professional networks.

Do I have to take part?

There is no obligation to take part in this study, and it is your choice whether or not you decide to be involved. If you decide to be involved and then change your mind, any referrals and/or decisions regarding the course of treatment or assessment for you and your child will be unaffected.

If you do agree to take part, you can then withdraw your data without giving a reason up until March 31st, 2023. After this date I will have begun analysing the data and therefore I will not be able to remove processed data from the project. If you do decide to withdraw from the project all data collected from you will be permanently destroyed and not used in the data analysis.

How will the recorded data be used?

The data will be comprised of recorded interviews which I will transcribe and analyse. All audio recordings from the interviews will be destroyed by the time the project is completed.

During the transcription process I will anonymise any identifying details to maintain the confidentiality of those involved or being talked about in the study. As such any identifying details will have been anonymised in the final Doctoral Thesis or any future publication of the work.

Data may be used in future academic presentations and publications. Learning from this project will be disseminated to colleagues within the Early Attachment Service and the wider Child and Adolescent Mental Health Service and a summary of the findings will be shared with participants, if they wish.

Confidentiality may be limited in the event where a participant discloses imminent harm to themselves or others. It may be that by taking part in this project, you and I come to the understanding that you would like, and are in need of, further support at which point I would refer you on to appropriate partner agencies.

What will happen to the recorded data?

I am responsible for looking after your information and using it properly. I will keep identifiable information about you from this study for up to 5 years after the study has finished.

Your right to access, change or move your information are limited, as I need to manage your information in specific ways in order for the data to be reliable and accurate. To safeguard your rights, I will use the minimum personally identifiable information possible. I will only use your name and the contact details you provide to contact you about the project. 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.

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

The data generated in the course of this project will be retained in accordance with the Tavistock and Portman Trust's Data Protection and Handling Policies. 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/

Are there any benefits to taking part?

It is hoped that you will find the interview a rewarding and helpful one, and that it will provide you with an opportunity to think more deeply about your child's experience and/or the experience of supporting a child and their family when there is emerging neurodiversity.

Are there any risks to taking part?

There are no direct risks to taking part in this study. However, there is a time commitment, and you may find that thinking in greater depth about how your child, or a child for whom you are part of the professional network, experiences their world can be difficult as well as rewarding.

If together we find out, during the course of the study, that you and your child would benefit from further support from other agencies I will make appropriate referrals with consent from you.

Contact Details

Please do not hesitate to contact me if you have questions about the project or would like to discuss anything further.

Jess Martin
Email: Jessica.martin30@nhs.net
Telephone: 0161 7163659
Address: Tameside and Glossop Early Attachment Service, 2nd Floor, 31 Clarence Arcade, Stamford Street, Ashton-Under-Lyne, OL6 7PT

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

Dr Jenifer Wakelyn
Email: Jwakelyn@tavi-port.nhs.uk

If you have any concerns about the conduct of this project, the researcher or any other aspects of the project please contact:

The Head of Academic Governance and Quality Assurance: academicquality@tavi-port.nhs.uk

Or

Dr Rajni Sharma – Director of Child and Adolescent Psychotherapy Training
Email: rajnisharma@nhs.net
Address: Northern School of Child and Adolescent Psychotherapy, Bevan House, 34-36 Springwell Road, Leeds, LS12 1AW

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 F – Participant consent

University of Essex | Northern School of Child and Adolescent Psychotherapy | NHS Pennine Care NHS Foundation Trust | The Tavistock and Portman NHS Foundation Trust

Participant Consent Form

Project Title: What is the experience of 'Watch Me Play!' for the professional network and for caregivers of young children with emerging neurodiverse development who are supported by an Early Attachment Service?

Name of Researcher: Jess Martin

1) I confirm that I have read and understood the Participant Information Sheet and have been given time to consider its contents. I confirm I have been given time to ask any questions I have about the study, and these have been answered satisfactorily.	
2) I understand that participation in this study is voluntary, and I am free to withdraw at any time without giving a reason, or withdraw any unprocessed data previously supplied. I understand that I can withdraw my data before 31st August 2023, after which time the data will have started to be analysed.	
3) I understand that the interviews will be audio recorded by the researcher and transcribed by an external transcription agency as described in the Participant Information Sheet.	
4) I understand that information I give in the interviews will be kept confidential by the researcher unless I or anyone else is considered to be at risk.	
5) I understand that whilst every effort will be made to ensure participant anonymity, the research participant group is small which may mean that it is easier to identify participants than if the group was bigger.	
6) I understand that participant confidentiality would need to be reconsidered in the occurrence of disclosure of harm to self or others.	
7) I understand that direct quotes from the interviews may be used in this research study but will be anonymised and held securely by the researcher.	
8) I understand that the results of this research will be published as part of a Doctoral Thesis and may form part of future publications or academic presentations.	
9) I understand that all data collected from the interview will be destroyed no longer than 2 years after the interview has taken place.	

10) I understand the interviews may involve the risk of emotional upset or discomfort, that I can stop the interview at any point and that I will be offered a chance to debrief after the interview has concluded.	

I confirm that I _____(Participant Name) have understood what is required of me, I agree to all the above and I consent to participate in this study.

Participant's Name (Printed): _____

Participant's Signature: _____ Date: _____

Researcher: Jess Martin

Signature: _____ Date: _____

Contact Details:

Researcher: Jess Martin Email: Jessica.martin30@nhs.net

Supervisor: Jenifer Wakelyn Email: JWakelyn@tavi-port.nhs.uk

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

Appendix G – Interview questions

Caregivers

Caregiver initials:
Child's initials:
Date:

INFORMATION
A What is your relationship to your child?
B How long have you known your child?
C How old is your child?

1. To begin, I wonder if you you and your child have been offered anything other than or as well as Watch Me Play!? And if so, what else?

2. Please can you tell me a bit about what kind of times you and your child have together?

3. Would you be able to share with me a little bit about how your child likes to play?
   - Special games, favourite toys, places, times of the day
   - Do you and your child find things you both enjoy or do you tend to have different interests?
   - What does your child particularly like or dislike in play?
   - When do they tend to play during the day?
   - Do they need anything that helps them to play? e.g. person with them, particular environment, sensory experience of play, timing

4. In relation to the Watch Me Play! intervention, I would like to hear about what you hoped to see? And did you see this?

5. Would you say these changes or developments were helped, or not, by Watch Me Play!?
   - In what ways?

6. How was it taking part in Watch Me Play!?

7. What do you think it was like for your child?

8. Were there any challenges with doing Watch Me Play! with your child – if yes, what were they?

9. Can you tell me about any ways you have continued to incorporate Watch Me Play! into you and your child's life since we finished together?

10. Do you think the work of Watch Me Play! has made a difference to the work of the professional network?
    - In what ways?

11. Anything else you'd like to share?

Professionals

Professional's initials:
Child's initials:
Date:

INFORMATION
A What is your role with the child?
B How long have you known the child?
C How old is the child?

1. Please could you tell me about your role in relation to the child?

2. I would like to hear about what you understand about Watch Me Play! approach?
   - It might be new to you, you might have heard of it before, you might have some experience of it, I would be interested to hear about all of this

3. What would you understand the experience of Watch Me Play! was for this child and their caregivers?
- Have you seen any changes in the child since they began 'Watch Me Play!' and if so, can you tell me about them?
- Have you noticed anything different about the caregivers since they began 'Watch Me Play!' and if so, can you tell me about this?

4. Has this work made a difference for you?
- And in what ways?
- Be prepared to explain in some more detail.

5. Has it made a difference for the network
- And in what ways?
- Be prepared to explain in some more detail.

6. As a member of the professional network, can you tell me about the ways in which members of the professional network think about the child, and whether that has changed?

7. Anything else you'd like to share?

Appendix H – Code labels

Code Labels	Frequency	Participant Range
WMP is child-led, it requires full adult attention, this can complement and confront caregivers approaches to play	19	7
Observation and play develop caregivers and professionals understanding of the child	16	7
Children with emerging ND can make choices in play which illuminates their individual and separate minds	25	6
At the child's level and joining in	22	6
WMP is most impactful at the beginning of relationships between child and caregiver	15	5
Children enjoy WMP	11	5
WMP is not widely known by professionals or caregivers	9	5
WMP is a developmental approach	6	5
Professionals and caregivers find WMP is not clearly defined	19	4
WMP is non-directive which can be hard for caregivers	14	4
Children with emerging neurodiversity play differently	14	4
Caregivers and professionals perceived WMP as creating lasting change	13	4
WMP relies upon, and facilitates, essential team around the child approach to multidisciplinary working in large and complex networks	13	4
Professionals not convinced by impact of WMP	11	4
WMP takes time	9	4
Professionals believe you have to be directly involved in WMP to understand it	7	4
WMP is hard to access because there are experts and gatekeepers	7	4
WMP offers new and alternative perspectives	6	4
WMP is experienced as helpful by caregivers and professionals	4	4
WMP can be an appreciated or denigrated reminder	17	3
Professional networks require clarity about aims and rationale of interventions	15	3
WMP is flexible and adaptable to meet the diverse needs of children with emerging ND	11	3
Caregivers and professionals want to learn WMP remotely and more quickly	8	3
WMP is more than just the box	7	3
Caregivers prioritise time with child due to WMP	7	3
Play as a dialog for children with communication difficulties	5	3
Different to normal play	4	3
Foster carers might struggle to ask for help	4	3
WMP supports children during transition	4	3
WMP challenges caregivers to see and do things differently	3	3
WMP offers hope to caregivers and professionals	3	3
WMP gives children a sense of belonging	3	3
Children's behaviour has meaning that can be better understood by providing choices through play	10	2
Caregivers of children with emerging neurodiversity are challenged by their child's play	7	2
Caregivers changed from more directive to less directive approach to play	7	2
WMP supports relationship building between caregivers and child	7	2
WMP gives caregivers confidence and a sense of agency	5	2
Professionals feel informed about but excluded from WMP	5	2

Children with emerging neurodiversity have missed out on what's needed to play	5	2
Overcoming difficulties through play	4	2
Caregivers need support to understand their child's play	3	2
WMP requires caregivers to learn something new	3	2
WMP leaves social workers feeling deskilled	3	2
WMP supports professional networks in decision making	3	2
Children and caregivers need support during transitions	3	2
WMP provides vital support to foster carers and adopters	3	2
When WMP is successful it sparks professional interest	3	2
WMP surprised caregivers and professionals	3	2
Learning and developing through play	2	2
WMP encourages caregivers to be self-reflective	4	1
Children feel seen and understood by caregivers in WMP	3	1
Professional networks are anxious during transitions	3	1
WMP helps children manage endings	3	1
WMP provides insight into children's emotional world	3	1
Foster carers find it challenging to play with their foster child	3	1
The suggestion of help can increase anxiety for foster carers	3	1
The way caregivers played with their child changed	2	1
It is different being a foster carer to being a parent	2	1
The offer of support can be felt as a judgement	2	1
The relationship building aspects of WMP can put off professionals and caregivers	2	1
WMP didn't help with the main concerns	2	1
Caregivers of children with additional needs or emerging ND require bespoke support as soon as possible	2	1
WMP is repeated and reliable which helps foster children	2	1
WMP only happens with the practitioner	2	1
WMP supports caregivers and children to manage experiences of separation	2	1
Caregivers saw unexpected developments in their child during WMP	2	1
WMP can assist in unpicking complex relational and developmental difficulties	1	1
WMP is more than just time together	1	1
Developmental concerns increase anxiety and reduces child-led play	1	1
When help is offered rather than asked for it can feel less valued	1	1
WMP is more effective when there are strong and long-lasting relationships between foster carers and social workers	1	1
WMP supports relationships developing within the network	1	1
WMP didn't provide new insights	1	1
Professionals just went along with WMP	1	1
Play is not the priority for busy social workers	1	1
WMP leaves caregivers feeling professionals see their child in the same way they do	1	1
Professionals appreciated WMP	1	1
WMP increases caregiver's empathy towards their child	1	1
WMP provides opportunities for children to express emotion	1	1
WMP is similar to other approaches	1	1

WMP incorporates concepts of trauma, relationships and development	1	1
The early history of children in foster care can be disturbing for their foster carers	1	1

Appendix I – Table of findings (Full)

1 How WMP is Understood	2 Potential Benefits of WMP	1 Challenges and Difficulties
1.1 WMP is a developmental approach - WMP is a developmental approach - Play as a dialog for children with communication difficulties - WMP is like other approaches e.g. PACE because it is child-led, meeting child where they are at, promoting relationships and attachments - WMP meets the child where they are at - WMP accepts the child's way of thinking - WMP incorporates concepts of trauma, relationships and development **1.2 WMP is child-led**	**2.1 For the child:** **2.1.1 Positive experiences for the child** - Children enjoy WMP - WMP gives children a sense of belonging - Children feel seen and understood by caregivers in WMP - WMP provides opportunities for child to express emotions - Child understands the box means playtime **2.1.2 WMP promotes child-led play by providing individual attention** - WMP promotes child-led play - WMP supports children to play for longer - WMP develops child-led play - WMP encourages children to make choices in play - Children with emerging ND benefit from making choices in play - Children with emerging ND benefit from freedom in play - Children with emerging need 1:1 play which WMP provides **2.1.3 WMP meets the needs of children with emerging ND** - Children with emerging ND feel accepted and included in WMP - WMP is flexible and adaptable to meet the needs of children with emerging ND - WMP is repeated and reliable which helps children, particularly with emerging ND and/or care experience 2.1.4 **WMP supports children facing transitions** - WMP helps children managing endings - WMP box of toys can be a helpful element of continuity at times of transition - WMP supports children during transition - WMP supports children and caregivers to manage experiences of separation - WMP is repeated and reliable which helps children, particularly children in care or with emerging ND **2.2 For caregivers:**	**3.1 For caregivers:** **3.1.1 Doing things differently** - Caregivers feel they already do WMP - WMP adds nothing new - WMP requires caregivers to learn something new - WMP requires an open mind - WMP challenges caregivers to see and do things differently - Some caregivers found WMP was only possible with the practitioner - WMP is non-directive, and this can be hard for some caregivers - WMP can make caregivers feel silly at the beginning - WMP requires full adult attention - It can be difficult for caregivers to understand their child's behaviour - Caregivers of children with emerging ND are challenged by their child's play - Caregivers of children with emerging ND struggle to understand their child's mind - Caregivers worry that WMP might not help their child with emerging ND's who cannot play - Play is limited for children with emerging ND - There is a concern that children with emerging ND have missed out on what's needed to play - Caregivers of children with emerging ND find child-led play confronting

- WMP is child-led - WMP is about showing interest in the child - WMP is about child's choice - WMP is learning and developing through child-led play - Different from normal play because caregivers hold back, stick with it, and the child plays for longer - WMP is non-directive - WMP is about getting on the child's level - WMP is about joining the child - WMP is a helpful reminder for caregivers to prioritise play time and focused attention with the child, and follow their child's lead in play - WMP is about seeing the world through the child's eyes	**2.2.1 Positive experiences for the caregiver** - WMP is experienced as helpful by caregivers - Caregivers find WMP interesting - WMP gives caregivers confidence and a sense of agency - Caregivers perceived WMP as facilitating lasting change - The WMP practitioner supports caregivers to stay engaged with their child's limited play - When caregivers see their child is developing, they can play more freely together - Caregivers saw unexpected developments in their child during WMP **2.2.2 Focus on attuning to and understanding the child through undivided adult attention** - WMP promotes focused attention on the child - WMP encourages adults to think about the child's play - WMP supports caregivers to understand their child's behaviour through play - WMP complements some caregivers' approach - WMP encourages caregivers to provide choice to children in play - WMP provides 1:1 play for children with emerging ND WMP illuminates the individual, and separate, minds of children with emerging ND for caregivers - WMP illuminates child's development - WMP provides a way into the child's world - WMP provides insight into the child's emotional world **2.2.3 A different way of being with the child** - In WMP the way caregivers played with their child changed - Caregivers become less directive through WMP - Caregivers continued to offer choices to their child after WMP - WMP encourages caregivers to hold back - WMP encourages caregivers to be curious about their child - WMP encourages caregivers to be self-reflective - WMP encourages playfulness in daily routines **2.2.4 Supporting caregivers to meet the needs of children in care** - WMP can provide support to children and caregivers during transitions - WMP can provide vital support to adopters and foster carers **<u>2.3 For the child-caregiver relationship:</u>** **2.3.1 Quality time** - WMP encourages caregivers prioritise time with their child	- Developmental concerns can increase anxiety and reduce child-led play **3.1.2 Timeliness of WMP** - Some caregivers felt WMP was needed sooner **3.1.3 Time investment** - WMP takes time to learn - WMP takes time to see benefits **<u>3.2 For the child-caregiver relationship</u>** **3.2.1 Being together** - The early history of children in foster carer can be disturbing for foster carers - Foster carers find it more challenging caring for a foster child than their own children - Foster carers find it challenging to play with their foster child **<u>3.3 For the professional network</u>** 3.3.1 Understanding the approach - Children in care with emerging ND have large professional networks - When help is offered rather than asked for it can feel less valuable to the professional network - Professionals find WMP is not clearly defined - Professionals require clarity around the aims and rationale of WMP - Preparation is needed with the professional network before WMP begins - Some professionals feel informed about, but excluded from, WMP - WMP is different to what some professionals imagine - WMP is not widely known by professionals - Some professionals feel there are experts and gatekeepers for WMP - WMP is not what's needed, or enough on its own, for all children

1.3 WMP can bring something new - WMP might provide new insights for the professional network - WMP is more than just the box - WMP is more than just time together - WMP supports a fundamental change in the way caregivers play and interact with their child, following his lead more, being less directional	- WMP provides time for caregivers and children to be together **2.3.2 Relationship building** - WMP supports relationship building - WMP increases caregivers' empathy towards their child - Overcoming difficulties through play - WMP encourages a meeting of minds between caregiver and child - WMP can assist in unpicking complex relational and developmental difficulties **<u>2.4 For the professional network:</u>** **2.4.1 Positive experiences for the professional network** - Professionals appreciated WMP - Professionals found WMP helpful - WMP reassures professional networks - WMP provides hope - When WMP is successful it sparks professional interest in the approach and the child - WMP promotes a joined-up approach in the professional network - Professionals perceived WMP as creating lasting change - WMP can support relationships developing between foster carers and adopters - WMP supports professional networks in decision making **2.4.2 Better understanding of the child** - Observation and play develop caregivers understanding of their child - Observation and play develop professionals understanding of the child - WMP provides opportunities for professional networks to think about the child - WMP provides professional networks with new insights - WMP provides insights about the child's emotional world for professionals - WMP can provide new perspectives for professionals - WMP can create a shared language to think about the child - WMP provides hope which is even more important for caregivers of children with emerging ND - WMP leaves caregivers feeling professionals see their child in the same way they do	- WMP needs involvement from professional network - When WMP draws attention to relationship building between children and foster carers, professionals worry this can increase anxiety and deter foster carers - The suggestion of help can increase anxiety for foster carers - Foster carers might struggle to ask for and accept help - WMP is more effective when there are strong and long-lasting relationships between foster carers and social workers - The offer of support can be felt as judgement **3.3.2 Involvement** - Professionals just went along with WMP - WMP leaves some social workers feeling deskilled - Some professionals are not convinced of the impact of WMP - Some professionals felt WMP did not provide new insights - WMP did not help with the main concerns - Some professionals believed you must be directly involved to understand WMP - Some professionals mistakenly believe the box of toys is the most important aspect of WMP - Play is not a priority for busy social workers - Professional networks are anxious during transitions

Appendix J – Implications for practice

Implications for Practice
In general ○ **Important that the aims of WMP are clear.** - Before implementing WMP with a family, establish goals/hopes/aims which are clearly discussed and articulated and shared effectively with the wider network. Also, clearly describe what WMP is and how it can meet the specific goals/hopes/aims. ○ **Some foster carers and adopters would like WMP training course.** - Foster carers and adopters are keen to be more aware of WMP and looking back wish they had known about it sooner. A training course for foster carers and adopters when registering and to refresh skills would increase awareness. ○ **Caregivers appreciate WMP that can be long-term.** - When introducing WMP it is important to consider caregivers' experience, skills, strengths and concerns. The duration of support needs to be flexible, responsive to the needs of the family, regularly reviewed with caregivers and the professional network, and potentially long-term e.g. have an opportunity to extend at each review (every 6-8 weeks). ○ **Effective WMP requires a professional network team approach.** - Information needs to be shared openly, preparation for WMP must include professional network liaison, and regular reviews and opportunities for discussion. ○ **Sharing observations and reflections from WMP with the professional network is needed so professionals understand the approach and feel involved.** - Reviews with the professional network are essential, at which, observations and reflections from WMP sessions can be shared to illuminate the work, and the child, to the professional network. **For children with emerging ND and their caregivers** ○ **Caregivers of children with additional needs and/or emerging ND require bespoke support as soon as possible.** - A professional network team approach will likely be required to meet the needs of this cohort, WMP has a valuable role to play, particularly early on in relationships, when caregivers may be struggling to understand their child. ○ **WMP training courses would benefit all foster carers, particularly if they are newly caring for a child with emerging ND.** - Being with a child with emerging ND whilst they play may not come naturally to caregiver or child. Caregivers need to sustain patience, persistence, flexibility, sensitivity, attunement and an open mind. This can be challenging and WMP can offer support. - WMP training course for new foster carers, or as a refresher for those caring for children with emerging ND for the first time, would give foster carers more confidence and awareness of what support is available e.g. WMP, if things get difficult, so they might feel able to ask for help sooner. **For children in care, their caregivers, and professional networks** ○ **WMP is most impactful at the beginning of relationships.** - Other professionals, foster carers and adopters need to be more aware of WMP and what it can help with, so that more families can be referred/can request WMP earlier on, especially for children in care with emerging ND. ○ **WMP can be used with foster carers, adopters, family members or new foster carers to support transitions.** - There is a place for WMP to support transitions for children between foster care and adoption, and it can support strong relationships between caregivers which supports an experience of continuity for the child.

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