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The Psychotherapist as the crucial factor in fostering the relationships in the triangle supporting the child: Second audit and evaluation of the Child Psychotherapy Service at the Randolph Beresford Early Years Centre

Inge-Martine Pretorius, Doron Batiste Harel and Peter Martin  
The Anna Freud National Centre for Children and Families, London

**Abstract**

Therapeutic programmes that offer early intervention may decrease the risk of developing emotional and behavioural difficulties in childhood and adulthood. This paper describes the Hammersmith & Fulham (H&F) Child and Adolescent Mental Health Service (CAMHS) Child Psychotherapy Service (CPS) that was established at Randolph Beresford Early Year Centre (RBEYC) in 2008. It presents the results of an audit and evaluation of the CPS. We used a Goal Based Outcome (GBO) measure to evaluate service-users' (parents' and caregivers') perceptions of progress toward treatment goals, and structured interviews with eight caregivers and ten staff members to explore their views of the CPS. Thematic analysis was used to summarize these views. GBO ratings indicated that all caregivers felt they had made progress towards reaching treatment goals by the end of the intervention. Interview responses suggest that all caregivers and staff perceived the CPS positively and thought that the RBEYC was successful in nurturing the child's overall development. The quality of relationships between staff, service-users and the CPS was perceived as central to the facilitative environment of the RBEYC. In particular, the psychotherapist was viewed as playing a critical role in facilitating this triangle of relationships supporting the child.

**Keywords:** early intervention, vulnerable population, audit and evaluation, thematic analysis

**Introduction**

'It (meeting the psychotherapist) helped me to think about how we might unconsciously get pulled into a situation with a child and sustain some behaviour. Understanding what is going on for a child helped me take a step back and work more objectively- same with parents' (Staff at the RBEYC)

‘Helping me to label feelings was helping him (child) have an understanding of himself – a profound shift, now he is able to articulate his feelings’ (Parent of boy attending the RBEYC nursery school)

‘It (meeting the psychotherapist) enabled me to notice and understand certain behaviour such as hyper-vigilance, as we discussed a child who was easily distracted by noise and indeed after a traumatic experience, was constantly checking the environment to make sure it was safe.’ (Staff at the RBEYC)

These words, spoken by service-users (caregivers and staff) at the RBEYC, evidence the insight, understanding and sense of empowerment that they gained from their meetings with the Child and Adolescent Psychotherapist based at the RBEYC.

Anna Freud’s wartime work (1941-1945) offered some of the earliest evidence that the environment influences early childhood development, later personality development and the emergence of psychopathology (A.Freud, 1973; Freud & Burlingham, 1944). Her work showed that environmental factors such as inadequate or rejecting attachment figures, together with personality factors such as poor frustration tolerance and poor affect regulation contributed to the development of psychopathology (A.Freud, 1982). In 1957, Anna Freud established the Hampstead Clinic Nursery which integrated early intervention into an educational nursery school setting (Friedmann, 1988; A.Freud, 1988). More recently, there have been further attempts to integrate preventive work into educational programmes, in order to minimize potential future developmental problems (Zaphiriou Woods, 2000; Jackson, 2005; Weis, 1995; Magiati, Charman, & Howlin, 2007). Creating a therapeutic provision, as part of the supportive, social and educational services within a nursery school setting, provides an atmosphere of acceptance and gives the child a sense of being part of a stable framework. Furthermore, it can help reduce the stigma associated with mental health services and consequently, improve engagement (Pretorius & Karni-Sharon 2012; Campion, 1984).

Numerous studies have shown that therapeutic programmes offering early intervention – early in the child’s life and early after identifying the difficulty – decrease the risk of developing emotional and behavioural difficulties in early childhood, as well as reduce mental health problems in adulthood. The therapeutic work may address difficulties before they are fully internalised and to provide aspects of the maternal and paternal functions to children who are in need and who lack adequate parenting. These interventions include changing the child’s environment by supporting the parents (Fraiberg, Adelson & Shapiro, 1975; Olds, Henderson, et al., 1998), psychotherapeutic interventions with mothers and their babies (Baradon, Fonagy, Bland, Lenard & Slead, 2008; Slead, Baradon & Fonagy, 2013; Fonagy, Slead & Baradon, 2016), psychoanalytically-informed interventions with the children and their parents in therapeutic parent-toddler groups (Steele, Murphy & Steele, 2010; Zaphiriou Woods & Pretorius, 2011, 2016), psychodynamic counselling with families and their young children (Pozzi, 1999), offering family therapy within a school setting (Campion, 1984), early interventions for children with ASD (Magiati, Charman & Howlin, 2007), as well as interventions with the professionals working with the families (Jackson, 2005).

Studies into the gene-environment interactions are confirming the lasting influence of the environment on the child's development. On a sub-cellular level, epigenetic research shows that environmental influences affect how and whether genes are expressed. The child's early experiences can determine whether and how genes are turned on and off and whether some are expressed at all (Meaney, 2010; Szyf, 2009a, 2009b). Thus, the experiences that children have early in life and their emotional environment shape their developing brain architecture and strongly affect whether children grow up to be healthy members of society. Nutritional status and exposure to toxins can modify the genome leading to temporary or enduring health problems (Bernstein, Meissner, & Lauder, 2007). Repetitive stressful experiences can cause epigenetic changes that damage the child's capacity to manage adversity in later life (Szyf, 2009a, 2009b; Bagot, van Hasselt, Champagne, Meaney, Krugers, & Joels, 2009). By contrast, supportive environments and rich learning experiences lead to positive epigenetic changes that establish a foundation for more effective learning capacities and greater capacity to manage adversity in the future (Curley, 2009, Sweatt, 2007, 2009).

Sally Davies (Chief Medical Officer, England) stated in the foreword of the '1001 critical days manifesto'; 'Those who suffer multiple adverse childhood events achieve less educationally, earn less, and are less healthy, making it more likely that the cycle of harm is perpetuated, in the following generation' (Leadsom, Field, Burstow & Lucas, 2015:1). It is now widely recognised that early intervention is essential to help mitigate difficulties in childhood which can lead to emotional, social and behavioural problems if unattended (Goodman, Joshi, Nasim & Taylor, 2015). Despite the evidence and interest expressed above, there is a dearth of reported research into psychotherapeutic intervention within early educational frameworks. This article evaluates a CPS that is embedded in an early educational setting, and thereby hopes to contribute to the body of knowledge.

This paper describes the unique features and scope of the CPS at the RBEYC. A brief case study illustrates the importance of liaising with professionals supporting the family to achieve a successful outcome. It illustrates the flexible approach required to engage and meet the needs of hard-to-reach families. This is followed by the results from the second audit and evaluation of the CPS which extends the first one (Pretorius & Karni-Sharon, 2012). The first audit covered the first 12 months of operation of the CPS, while the second audit covered a 20-month period from September 2011 to April 2013, 5 years later. A qualitative analysis (Smith, 2003) was conducted on the responses of caregivers and staff, to a semi-structured questionnaire. Goals-based outcomes (GBO, Law, 2011) and demographic data obtained from the children's files were analysed. The article shows the important role that a CPS can play in intervening early in order to prevent behavioural and emotional problems from becoming entrenched in children. In particular, it argues that the psychotherapist played a crucial role in building the triangle of relationships between the CPS, nursery staff and parents, in order to support the child's development.

### **The CPS**

Established in 2008, the CPS is run by a Child and Adolescent Psychotherapist (IM Pretorius) who is based in the RBEYC 2 days per week, but who visits the H&F CAMHS regularly for supervision, training and management. The RBEYC is a Local Authority provision in an ethnically mixed, very deprived area of H&F. The establishment, development and setting of the CPS are described elsewhere (Pretorius & Karni-Sharon, 2012; Pretorius & Martin, 2016).

The CPS offers short- or longer-term consultations to caregivers, caregiver-child psychotherapy, and individual child psychotherapy to children. It supports staff by offering individual meetings, regular end-of-day meetings to discuss children and by presenting workshops at staff meetings. Families can self-refer or be referred by the Senior Management Team (SMT) or Family Support Service (FSS) at the RBEYC. There are no thresholds with respect to the nature or severity of problems for a referral to be made. The therapist works very closely with the SMT and FSS who usually attend the Child Protection and Child in Need Meetings which protects the psychotherapeutic relationship with the family. Following a referral, families are usually offered an appointment within two weeks.

### **Case example of longer-term parent-child psychotherapy**

Max (a pseudonym) aged, 2 years 5 months, was referred to the CPS, because he was soiling and wetting at nursery and home, having previously mastered his toileting. He had also started protesting when his mother brought him to nursery. The referral followed an incidence of parental domestic violence (DV), during which Max saw the police arrest his father. His mother was advised by the SLT to meet the psychotherapist to help Max deal with his experiences and to think about the impact of the parental conflict on his development.

Mother missed the first appointment. She attended the next one, saying that she only came because she trusted Max's teacher and the nursery school. She spoke about growing up in her home country where she began misusing alcohol and was diagnosed with a personality disorder, as a teenager. She moved to the UK where she met Max's father. Their relationship was 'passionate and volatile' and Max witnessed DV from birth. Following father's arrest, Max resumed using a bottle, came into her bed at night and started to wet, soil and refuse to stay at nursery. He was placed on a Child in Need plan (CIN).

During this meeting, Mother set the goals together with the therapist. Mother rated the extent to which she thought they were reached (0 – 10 scale).

1. Help Max to stop soiling and wetting, 0/10
2. Help Max listen to his mother, 2/10
3. Help mother manage Max' controlling and aggressive behaviour, 2/10

Mother was offered weekly appointments. She missed the next two appointments, attended one and then missed one, apparently needing to regulate her contact with the therapist. When the therapist mentioned her absence, she said that weekly meetings upset her too much. They

agreed to meet bi-weekly and mother attended the next 4 sessions. She was convinced that Max refused to stay at nursery, because he was being bullied. He told her that he had no friends. She tried to console him by confiding in him, telling him she was his 'best friend' and he needed no-one else. Max seemed to be caught in a loyalty conflict between his mother and his peers. Max' teacher reported that Max played regularly with two boys.

According to mother, Max was very controlling at home 'just like his father'; he chose which DVDs they watched and if he wanted her armchair, he swore and kicked her until she moved. It was difficult for her to see him as a frightened boy; instead she tended to see his violent father. The therapist suggested that Max attend the sessions to work on difficulties as they arose. This seemed to give her some agency that enabled her to engage more fully with the therapy. After that, they only missed 3 appointments, during the parent-child psychotherapy that continued for over 2 years.

Max scowled at the therapist throughout the first session and stayed close to mother. He actively turned away from the therapist when she addressed him and ordered the toy animals into pairs. He remained vigilant of his mother and approached her when she became upset. His play showed a striking absence of aggression, but he showed palpable hostility towards the therapist – the unwanted third. The therapist commented on this and mother said he behaved similarly at home; he became so aggressive when friends visited, they had to leave.

While addressing both Max and his mother, the therapist discussed his reluctance to stay at nursery and wish to sleep in mother's bed. She said she wondered if Max protested not because he disliked nursery, but because he was worried about leaving mother. Max rushed to give mother a tissue, as she became tearful. Mother said, 'Max has lost his father and now he is afraid of losing me.' Max snuggled onto her lap. The therapist said that Max might also be worried about mother's safety, while he was at nursery.

Staff and therapist worked on helping the mother set appropriate boundaries for Max. In therapy, this meant helping Max accept that sessions included the therapist who spoke about his wish to possess his mother exclusively. Over time, he tolerated the therapist, but never really interacted with her. Because Max went to bed whenever he wished, the therapist encouraged establishing a bedtime routine and treating Max like a child rather than a partner or 'best friend'. He gradually accepted the bedtime routine and fell asleep in his own bed.

While his soiling and wetting at school stopped, it continued at home. Max' mother said she felt guilty for what she had 'put him through,' so she changed his clothes immediately. Mother's guilt seemed to prevent her from expressing appropriate annoyance and disgust to help Max develop a reaction formation to his soiling. When the therapist asked Max how he managed to use the toilet at nursery, but not at home, he smiled triumphantly and turned away. Mother said he did the same at home which 'infuriated' her. This enabled mother to begin to think that Max's soiling and wetting was a way of keeping her involved. The therapist suggested that mother tell him to clean and change himself, and only offer help when necessary. The soiling and wetting soon stopped.

Having mastered his toileting again, Max started having tantrums, which frightened mother. This new behaviour occurred when she set boundaries. In a session with mother alone, she said that she never had tantrums as a child, because her mother beat her if she protested. She said that when Max had a tantrum, he looked 'just like his violent father'. Her difficulty with expressing and managing anger and aggression – her own and Max's – was becoming clearer to her. The therapist thought that the tantrums were a more age-appropriate expression of strong feelings than the regressive soiling and wetting. The tantrums suggested a growing capacity in both mother and child to express and bear some aggressivity.

Ten months into therapy, Max' father was released from prison, started supervised contact with Max and the CIN plan was closed. During this period, the therapist met twice with Max' parents individually, to help them think about their parenting. Max and mother continued bi-weekly therapy. Sixteen months into therapy, the SLT re-referred Max to the Children's Services. Mother had come to collect him inebriated and - it emerged later - had left Max with his father in a potentially dangerous situation. At a meeting with mother alone, she admitted abusing alcohol throughout the therapeutic work. Max now had only telephone contact with his father. Max refused again to come to nursery and began soiling at home and nursery. Because staff can easily become exasperated and annoyed with a child who soils, the therapist met staff regularly to enable them to remain empathic and see Max' behaviour as an angry, but also anguished cry for help.

When the therapist suggested to Max and mother in a session that he might be soiling, because he was angry, mother immediately corrected her, saying Max was not angry, but sad about his father's absence. She was able to think about his sadness, but not his anger. Nonetheless, after that session, Max stopped soiling and wetting. Mother embarked on a programme which included group therapy sessions to deal with her alcohol problem.

In the next session, mother said that if she became stern with Max, he immediately asked if she would leave him. The therapist spoke directly to Max saying that he was worried that if people got angry, like his mum and dad in the past, someone would leave. Max looked at her briefly, before returning to play with the police cars.

In subsequent sessions, mother said that she was beginning to think that Max was angry with his father, because Max sometimes refused to speak to him on the phone. Mother told Max that his father would feel sad and rejected and coerced him to speak. The therapist said that his father may have to bear those feelings. Mother was surprised, but then agreed that Max had every right to feel angry with his unreliable father. She stopped pressurising Max to speak with him. She began to show some understanding of Max's complex feelings and spoke with him about his longing for his father, anger at feeling abandoned, fear and confusion about father's violence. Max was happy to stay at nursery, again.

Mother continued the rehabilitation programme and proudly announced the length of her alcohol abstinence at each session. She said that in the group sessions, she started questioning

her tendency to forgive and reconcile with Max' father in the hope that he would change. She maintained routines and appropriate boundaries for Max who slept in his own bed. She no longer confided in him, but said she was pleased that he played with his friends.

In sessions, Max' play became less repetitive and developed more coherent narratives, usually involving police car chases. Although he did not actively engage the therapist, mother said that he sometimes repeated the therapist's words afterwards, suggesting that he was listening carefully. As Max was due to transfer to primary school, mother began to plan for the future. She began to consider both their needs and decided to return to her home country to enjoy her extended family's support. During the penultimate session, more than two years after starting therapy, they revisited the treatment goals and the mother evaluated her progress towards them.

1. Help Max to stop soiling and wetting, 10 /10
2. Help Max listen to his mother, 8/10
3. Help mother manage Max' controlling and aggressive behaviour, 8/10

The therapy ended when Max (4 years 8 months) left the nursery.

The case illustrates the need for a flexible approach to suit the family's needs including working with one or both parents and on the mother-child relationship. It highlights the importance of working with staff. The mother engaged with the CPS because she transferred her trust in the teachers to the therapist, evidencing the importance of embedding a CPS within the nursery school.

### **Audit and evaluation of the CPS**

The audit and evaluation covered a period of 20 months from September 2011 to April 2013, 5 years after the first audit (Pretorius & Karni-Sharon, 2012). In exploring perceptions of the CPS, the first audit concluded:

'Service-users felt heard, understood and contained by meetings with the psychotherapist. Mothers felt more empowered to deal with the difficulties they encountered with their children. Staff felt they became more reflective and consequently, understood and dealt better with the children and their families' (Pretorius & Karni-Sharon, 2012:182).

The second audit had three aims: to conduct a thorough audit of patients' files to gain understanding of the nature of referrals and user population; to assess the effectiveness of the CPS as perceived by the caregivers and staff members; and to verify the conclusions of the first evaluation by conducting further data analysis.

## **Methods**

### **Participants**

The participants comprised two groups; eight caregivers (six mothers and two maternal grandmothers) who were current or past service users; and ten female staff members (approximately 21% of staff). The recruitment of caregivers was conducted by the psychotherapist at the RBEYC. She informed them about the audit and invited them to participate. Since the study was dealing with a vulnerable population, it was deemed necessary to enlist the psychotherapist's help recruiting, in order to ensure that caregivers were properly informed and were agreeing to participate only when it was felt they were giving informed consent. Regarding staff participants, the Head Teacher introduced the research at a staff meeting and invited colleagues to participate. Staff who volunteered were then contacted by the student researcher who conducted the interviews (Doron Batiste Harel).

### Measures

Semi-structured interviews. The researcher conducted semi-structured interviews with both groups of participants. The interview schedule was based on that used in the first audit (Pretorius & Karni-Sharon, 2012). A small number of questions were added to probe for participant's feelings, an area that we felt had been underexplored in the first audit. Interviews were audio-recorded and transcribed.

GBQ. Since almost all the children in our study were younger than five, the goals (pertaining to child and caregiver) were chosen by the caregiver during the initial therapy meeting. The caregiver rated the progress towards each goal on a scale of 0 (*not at all*) to 10 (*fully met*) at the start and end of treatment.

ICD-10 diagnoses and risk factors. Children were given ICD-10 diagnoses and risk factors (World Health Organisation, 1992), following a discussion between the psychotherapist and the Consultant Child and Adolescent Psychiatrist at H&F CAMHS.

### Data analysis

Semi-structured questionnaires. In order to gain an understanding of the participants' experiences of the CPS, interview transcripts were subjected to qualitative thematic analysis (Smith, 2003).

GBQ. In order to gain an understanding of the kinds of goals parents chose and the extent to which they perceived they reached them, the goals (38) were collected from 16 cases whose treatment was complete. Using thematic analysis, a typology of goals was developed. We also evaluated progress towards treatment goals using descriptive statistics.

Clinical files. A quantitative analysis was conducted on children's files who received treatment during the audit period. Descriptive statistics were used for demographic data, attendance and length of treatment, ICD-10 diagnoses and other characteristics.

### Ethical approval

Ethical approval for the audit and evaluation was received from the West London Mental Health NHS Trust in October 2012, and from University College London in January 2013 (Project ID: 0384/082).

## **Results**

The findings are presented in four parts: the descriptive data of the children, families and staff using the service; the GBO analysis; interviews with caregivers; and interviews with nursery staff.

### **1. Descriptive data of children and families using the CPS**

During the 20-month audit, 93 children (58 boys and 35 girls) and their families used the CPS. All staff used the CPS, i.e. each staff member had at least one individual and at least one group meeting with the therapist. Table 1 presents a summary of CPS appointments (Appointments for two or more siblings are counted only once). Appointments with parent and/or children were 50 minutes long, while those for staff were 30–50 minutes long. Staff usually got appointments on the same or next day after they requested one. Following a referral, some families received an appointment on the following day. No families waited more than two weeks for their first appointment. (This waiting time is within the context of the psychotherapist only working two days per week). Tables 2-4 below, present the children's ethnicity, demographic details and ICD-10 Risk Factors.

Table 1. Summary of CPT appointments

Number of appointments offered to caregiver(s) and/or children	259
Number of consultations to staff	266
Number of appointments missed	54 (10%)

Table 2. Ethnicity of the children

<b>Ethnicity</b>	<b>Number of children</b>	<b>%</b>
<b>Mixed</b>	22	23.7
<b>Black Caribbean</b>	21	22.6
<b>Black African</b>	16	17.2
<b>White British</b>	16	17.2
<b>Asian</b>	6	6.5
<b>Other</b>	6	6.5
<b>White other</b>	4	4.3
<b>Black other</b>	2	2.2
<b>Total</b>	93	100

Table 3. Most prevalent ICD-10 risk factors

<b>ICD-10</b>	<b>Description</b>	<b>% children</b>
<b>Z61.7</b>	Personal frightening experience in childhood	34.6
<b>Z62.4</b>	Emotional neglect of child	31.8
<b>Z63.5</b>	Disruption of family by separation and divorce	19.3
<b>Z81.8</b>	Family history of other mental and behavioural disorder	19.3

Table 4. Information about the child and family

	<b>Number of children</b>	<b>%</b>
<b>Parent(s) involved in domestic violence</b>	33	35.5
<b>Child has Child in Need or Child Protection Plan</b>	31	33.5
<b>Parent(s) with known mental health diagnosis/disorder</b>	16	17.2
<b>Parent(s) with a known criminal record</b>	16	17.2
<b>Child in care, currently or in the past</b>	10	10.5
<b>Parent(s) misusing drugs and/or alcohol</b>	8	8.6
<b>Parent(s) with a chronic physical problem</b>	7	7.5
<b>Child has special needs</b>	6	6.5
<b>Mother is a teenager</b>	6	6.5

## 2. Analysis of the GBO

There were 19 episodes of care for which goals were rated, referring to 18 different child-caregiver pairs (one child was referred twice in the observation period). Altogether, 46 goals were set. Of these, 43 had a rating at the beginning of treatment ('Time 1'), and 45 had a rating at the end ('Time 2'). At treatment start, 36 goals were rated as 0, six were rated as 1, and one goal was rated as 2. The mean rating was 0.2.

At treatment end, goal progress ratings ranged from 5 to 10, with a mean of 8.4 and a median of 9. Change could be assessed for 42 goals, which had ratings both at Time 1 and Time 2. Change scores ranged from +5 to +10 (so that all change scores indicated progress toward the goal), with a mean of 8.1 and a median of 8.5.

We now turn to our thematic analysis of goal content. Twenty-six goals were related to helping the child overcome his/her difficulties; the remainder focused more on the caregivers' own difficulties. The themes are summarized in Table 5.

Table 1. A typology of treatment goals set by caregivers

Main themes	Sub-themes	Examples
Caregivers' goals for the child	1. Boundaries	to learn to respect her parents by stopping any backchat or insolent rolling of the eyes
	2. Gaining self-regulation and control	to help the child to manage his anger
	3. Other goals	making friends and enhancing communication skills
Caregivers' goals for themselves	1. Mutual support between parents	parents to support each other in disciplining their child by refraining from giggling in front of the child and thus, undermining each other
	2. Improve parental functioning	establish a consistent bed-time routine
	3. Gain understanding	to learn to understand what feelings the child is expressing through her behaviour

### 3. Thematic analysis of the interviews with caregivers

The eight caregivers interviewed (six mothers and two grandmothers) were 26-54 years old ( $M=38.25$ ,  $SD=10.2$ ). Treatment duration and session frequency varied for the cases. Six received 5-12 meetings, while two had weekly meetings over a long period of time. When asked about the number of sessions, five participants said it had been 'about the right number,' one said, 'not enough', one said, 'more than enough' and one said 'too much'. In response to the question, 'Have you found the meetings with the therapist helpful', all caregivers scored 4 (helpful) or 5 (very helpful) out of a possible 5, ( $M=4.62$ ,  $SD=0.5$ ). All caregivers said that as a result of meeting the therapist, their child's behaviour improved (scoring 4 or 5 out of 5,

M=4.75, SD=0.4), their relationship with the child improved (scoring 4 or 5 out of 5, M=4.83, SD=0.4).

The caregivers' responses were grouped into five main categories:

1. Caregivers' perceptions of the meetings with the therapist.
2. Caregivers' perceptions of their own gains from meeting the therapist.
3. Caregivers' perception of the child's gains from meeting the therapist.
4. Caregivers' perception of the therapist working (offering appointments) in the nursery.
5. Caregivers' overall experience of the Service.

The themes and sub-themes identified within these five categories are summarised in Table 6.

**Table 6: Caregivers' perception of child psychotherapy**

Caregivers' perceptions of:	Main themes	Sub-themes	Example quotations
Meetings with therapist	Someone to speak to / Holding environment		'At first I couldn't understand what it would do for me. But now I think that in the second meeting it helped me to release lots of things that I was worried about. Be able to share my experience with someone.'
	Learning experience	1. New perspectives on the child's behaviour and feelings	'I am now understanding a bit more about what she is feeling emotionally... I just took it for granted that she would be fine...but now it is so much better and I understand where she is coming from.'
		2. Practical guidance about dealing with the child	One caregiver noted that the therapist gave her 'solutions to the crying problem during reception time... because it was difficult for the child to be separate...everything that came up during the sessions that I put into practice was very helpful.'
Caregivers' gains from meeting therapist	New ways of relating	1.Improved caregiver-child relationship	'now I think about the best interest for the child even if it is different from [...] my own.'
		2.Caregivers change their perspectives on their child's capabilities	'I respect my child more as a person. Before it was just 'do what you have been told!' But now there is a different approach- you respect that the child is someone who has his own opinion and it is regardless which age he is.'
		3. Gain confidence as a caregiver	'[I am] more confident as a mother and [I] can deal with issues in a certain way now [...]. Now I feel more in control.'
Child's gains from meeting therapist	Developmental progress after change in parent-child relationship		'helping me to label feelings was helping him [child] have an understanding of himself- a profound shift, now he is able to articulate his feelings.'
Therapist working in the nursery	Link between education and therapy		'I think that the fact that the therapist is here [in the nursery] encourages them [caregivers] to go to speak to her. If it was somewhere else I don't think it would encourage them to go. The waiting list through the council is so long and I was very fortunate to get it [appointments with the therapist]. I think every school needs a therapist.'
Overall experience of Service	Positive perception		All caregivers praised the psychotherapy service, using words such as 'brilliant,' 'fantastic,' 'great,' and 'all helpful.' When asked if they would change anything in the service, they requested an increase in the number of days that the therapist could be available.

### **3.4 Thematic analysis of the interviews with staff**

The ten staff members interviewed were 30-55 years old (M=41.4, SD=9.5). In addition to meetings attended by groups of staff, eight staff members had 2-6 individual meetings with the therapist. Two had meetings every 2-3 weeks over a long period.

In response to the question, 'How helpful were the meetings that focussed on one child,' all staff members scored 4 (helpful) or 5 (very helpful) out of a maximum score of 5 (M=4.8, SD=0.3). In addition, staff scored high on the question relating to the helpfulness of the more general meetings (M=4.8, SD=0.3). All staff chose high scores of 4 or 5 out of 5 (M=4.8, SD=0.4) to describe the improvements in the child's behaviour, following meetings with the therapist.

Staff responses were grouped into four main categories:

1. Staff's perceptions of the meetings with the therapist.
2. Staff's perceptions of their gains from meeting the therapist.
3. Staff's perceptions of a therapist working (offering appointments) in the nursery.
4. Staff's overall experience of the service.

The themes and sub-themes within these four categories are summarised in Table 7.

Table 7. Summary of themes and sub-themes of the thematic analysis drawn from the staff interviews.

Nursery staff's perception of:	Main theme	Sub-theme	Example quotation
Meetings with therapist	Safe time and space / holding environment		'It was really helpful to know we got another professional on our side and someone you can run back to and say 'I need her help'. Because when you need to hear that you are doing fine and it will get better and just having that external link makes you feel you can do this. The support and input helps you to move on. Knowing you not on your own and you can get help...If I cannot support myself so how I suppose to support the child?'
	Learning experience	Development of self-reflection	'She [the therapist] would get us to recognize what we were doing and what was happening to us and therefore to think how to deal with it - this definitely encouraged different ways of thinking.'
		Becoming an observer	Meeting the therapist individually or during staff meetings helped the staff to developed observation skills. They reported that they could make inferences from one case to another, as well as develop an understanding of the child's perspective.
	The therapist as an integral part of the service		'When you are so involved with a child every day it is quite hard to stand back and think. Having the therapist's perspective as an outsider helps us to see things from different angle and place the behaviour [of children] in a much wider context.'
Staff gain from meetings with therapist	A shift in the way of thinking / self-empowerment		'She [therapist] helps us to see things from a different perspective and alters our behaviour slightly. For example, we used to perceive the behaviour of a particular child who threw things as unwanted behaviour. But we were able to think differently with her [therapist] help and to that he was trying to make social contact with us - actually rather than focusing on the negative behaviour you can say to the child: 'do you want to play with me?' To see it in a positive way is not always easy for us, suggesting how we respond to that child had made a massive difference'.
	Becoming able to share experience		'People were able to communicate and to help with situations you don't feel comfortable with - you are able to say to your colleague, 'look I'm feeling like this. What do I need to do?' And then you get feedback that makes you think, I'm not by my own'.
	Child changes in response to change in staff's behaviour		'First we didn't know what to do. A change in our attitudes toward the child who was aggressive led to a change in his attitude towards us and the relationship with him become alive. He became completely different or we perceived him to be different'.
The therapist within the nursery	The importance of location		'You can have a conversation [with the therapist] even when just in passing. If she [the therapist] were somewhere else we wouldn't nearly be able to have such an opportunity and it wouldn't be fulfilling as it is.'
Overall experience of service	Valuable service		'[The CPS is] a great opportunity for the staff and parents to talk about their worries and anxiety, it is a welcoming environment'

## Discussion

The present study aimed to evaluate the RBEYC CPS through exploring three data sources: descriptive statistics of the service-user population, semi-structured interviews with caregivers and staff, treatment goals set by caregivers with progress ratings to evaluate subjective goal achievement. We will discuss the findings from each of these data sources, in turn.

### 4.1. Summary of findings from clinical files

Most service users received appointments on the day of referral or on the following day and none waited more than two weeks for their first appointment. Importantly, only 54 (10%) appointments were not attended, which is lower than the 12% reported in the first audit (Pretorius & Karni-Sharon, 2012) and lower than the non-attendance rates at the H&F CAMHS for the same period. The CAMHS non-attendance rates were 12.6% for first appointments, 15.8% for follow-up appointments and 14.2% for total non-attendance of first and follow-up appointments (personal communication, Susie Hook, Service Manager H&F CAMHS).

### 4.2. Summary findings relating to treatment goals

Caregivers tended to set goals that were behaviour-based, rather than related to feelings. Most goals focused on a problem located in the child rather than in the caregiver or caregiver-child relationship. These results are consistent with those of Weisz & Weiss (1991) and Hawley & Weisz (2003) who found that parents, children and therapists were more likely to report externalised problems (i.e. aggressive behaviour, delinquency) than on internal problems (i.e. withdrawal, somatisation, anxiety/depression).

Goals were set at the beginning of therapy. The findings from the caregivers, discussed below, suggested that as therapy progressed, caregivers changed their perception of the problems identified at Time 1. Initially, caregivers tended to locate the problem in the child, for instance, 'he does not listen to me' which often left them feeling helpless. However, as caregivers became more aware as therapy progressed, many began to recognise their contribution to the problem. While this was a slow and sometimes painful process of introspection, it empowered caregivers with the ability to influence and change the problem, for instance 'I need to be firmer and consistent'.

### 4.3. Summary of findings from the interviews with caregivers and staff

The responses to the interviews with caregivers and staff were detailed enough to analyse by thematic analysis. This contrasted with the first audit (Pretorius & Karni-Sharon, 2012) in which parents' responses were so brief that only quantitative content analysis could be applied. This suggests that the present study's additional questions focussing on participants' feelings succeeded in eliciting more detailed responses.

There were similarities in the interview content of both caregivers and staff. Both groups felt that a change in the adult's attitudes resulted in a change in child's attitudes, suggesting the adult environment's influence on the child's development (A. Freud 1953). Both groups shared the same sub-theme of 'holding environment', a concept described by Winnicott (1965). They felt that the meetings with the therapist provided a safe environment where they could express their feelings and thoughts without criticism. Consistent with the first audit (Pretorius & Karni-Sharon, 2012), both groups emphasized that it was important and advantageous that the CPS was located in the RBEYC, as this familiar setting increased appointment attendance. An

earlier audit of the CPS in four primary schools in H&F (Maroni, 2007) found that children who had failed to attend therapy in CAMHS, attended sessions when they were offered in the school. The children's parents felt that the school setting was less threatening and stigmatising than visiting CAMHS.

Although staff and caregivers described the meeting with the therapist as a 'learning experience,' what they perceived themselves to have learned differed between groups. Caregivers responses suggest that some of them developed, maybe for the first time, a psychological approach to understanding their child's behaviour; others appreciated learning new ways of practically managing their child. In contrast, staff described how they developed their capacity both for self-reflection and close observation of the children and parents. These findings are consistent with those of Jackson (2005) who analysed Work Discussion groups offered to staff in schools and found that staff improved their observation skills and capacity for self-reflection, and as a result, staff listened better to pupils and felt more confident about their work. In the present research, staff also reported becoming more confident and better able to answer the child's needs as a result of their consultations with the therapist.

We suggest that the personal development of staff has the capacity to impact positively on their own work and on their collaboration with colleagues, thereby creating a virtuous circle of mutual learning. From this perspective, the quality of relationships between staff, the therapist and service-users are vital for a successful service.

#### 4.4. Limitations

Although we would like to think that a similar structure and CPS in other centres could produce comparable results, it is clear that this study was conducted in a specific setting, with a specific population, and involving a single therapist, so that it is unclear how far we can generalize our conclusions. Neither can we distinguish rigorously the causal factors that may have been responsible for the positive outcomes observed; these may include the setting, the abilities of the nursery staff, and the abilities of the psychotherapist.

One limitation concerns recruiting the caregivers. The psychotherapist was thought to be in the best position to approach caregivers to participate. However, this may have biased the results, as caregivers who volunteered might have been more likely to hold positive views of the CPS, while those holding negative views may not have been captured in the sample. Although the researcher emphasised the confidential nature of interviews, some participants may have believed that information might be shared with the therapist or nursery and so may not have been completely honest in their responses. Social compliance is a potential limitation of all interviews and so not unique to the present research.

#### Summary

The article shows the important role that a CPS can play in intervening early in order to prevent behavioural and emotional problems from becoming entrenched in children. In particular, it argues that the psychotherapist played a crucial role in building the triangle of relationships between the CPS, nursery staff and parents, in order to support the child's development.

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