AIMS Medical Science

AIMS Medical Science, 11(2): 181–209.
DOI: 10.3934/medsci.2024015
Received: 10 March 2024
Revised: 21 May 2024
Accepted: 14 June 2024
Published: 26 June 2024

http://www.aimspress.com/journal/medicalScience

Perspective

Integrative child psychotherapy: discussion of a common core and unified theory approach

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Abstract: This paper explored significant advancements in integrative child psychotherapy in the UK, aiming to establish a common core and unified theory. Informed by infant-parent observations, attachment theory, neuroscience, and socio-cognitive developmental psychology research, the findings integrated clinical approaches from a developmental and family systems perspective. The objective was to provide a framework based on common factors and a unified psychogenesis theory, emphasising a therapeutic action model and understanding child development. The escalating prevalence and severity of mental health issues among children and young people (CYP) are highlighted, with factors like the COVID-19 pandemic, educational disruptions, increased digital reliance, and the current cost of living crisis contributing to the surge. The impact of these changes necessitates a holistic approach to mental health care, specifically by specialists in integrative child psychotherapy. Current data underestimates CYP mental health needs due to the absence of a national approach to data collection and analysis. Moreover, there is a lack of consensus on the assessment and case formulation in CYP mental health treatment. The diversity in practitioners' approaches, training, and understanding of child development, evidence-based practices, and CYP mental health support is noted. Critiquing the limitations of evidence-based practices, the paper argues for a systematic assessment and case formulation framework. It advocates for an evidence base that acknowledges the individuality of CYP, emphasising psychotherapy's dynamic, relational foundation. The proposed framework seeks to inform training and practice requirements, challenging

the conventional mechanistic understanding of mental health treatment and promoting a more integrative and client-centred approach.

Keywords: integrative child psychotherapy; evidence-based practice; common core; unified approach

1. Introduction

1.1. What is integrative child psychotherapy?

Integrative child psychotherapy is a therapeutic intervention for working with children and young people (CYP)[1] who present with mental health needs. The expertise required to work therapeutically with this age range is extensive and relies on knowledge of children's psychological, social, neurological, biological, and spiritual–cultural development, typical and atypical for particular age groups (from pre-school to young adult[2]). Furthermore, a holistic and sophisticated understanding of childhood psychopathology, together with genetic,environmental and medical influences, (such as the impact of COVID 19 see [1]) as well as the complex interplay between various risk and protective factors, is needed for working with young clients, their parents/carers, and other professionals. Integrative child psychotherapy is rooted in developmental theory, neuroscience, psychological research, practice-based research findings, and clinical judgement to provide and offer a foundation of professional, evidence-based practice within family, educational, and health-related contexts.

This discussion paper focuses on defining integrative child psychotherapy within the context of the latest developments in child mental health practice that have been taking place in the UK in recent years, against a backdrop of underfunding and a challenging political and socio-economic climate [2]. Currently, there is a lack of recognition of integrative child psychotherapy. However, there is a significant need for specialist and focused child psychotherapy provision founded on a minimum of master's level education and training, with appropriately qualified and experienced supervisors to oversee the integration of theory into practice. Furthermore, there is a need to highlight the fundamental differences between child and adult psychotherapy. The authors feel these differences need to be underscored, and the role of integrative child psychotherapists needs to be appropriately recognised and integrated within the national mental health service.

Many of the distinctions between adult and child psychotherapy have been covered by Drewes and Seymour and are summarised under the five following fundamental differences presented in child psychotherapy[3]:

1. Expertise in child development is a key requirement. Child psychotherapy must be informed by an understanding of social, neuro-cognitive, emotional, and biological typical and atypical

[1] The use of the terms "children" and "young people" covers the age range from birth to 25 years. We use the term "children" to refer to younger children who do not have the maturity and understanding to make important decisions for themselves.

[2] We use the term "young adult" and "young people" to refer to those aged 18–25 years old and more experienced children who are more likely to be able to make these decisions for themselves.

development and with an appreciation of the significance that life transitions and experiences may have on a young client's development.

2. Therapeutic work with young clients must consider that a child's personality is still developing.
3. Children's motivations for attending therapy differ significantly from adults; hence, there will be varying degrees of acceptance, compliance, and resistance from young clients who may not understand the purpose or process of therapy or why they are attending.
4. Children may not recognise or agree there is a problem.
5. Children are less cognitively, socially, emotionally, and linguistically developed than adults.

Thus, young clients' will present with differential developmental abilities in their cognitive, reflective, and abstract thinking, as well as their ability to communicate their thoughts, emotions, and experiences. For this reason, the medium for therapeutic work must be less reliant on verbal interactions and instead on creative and play-based activities.

Given these complexities and fundamental differences in the therapeutic work with adults, Drewes and Seymour argue that working therapeutically with children requires an integrative approach [3], as one theoretical orientation or single approach to treatment cannot fit all presenting problems and complex circumstances. It requires specific training and supervision to understand children's developmental stages, their systemic environments, referral reasons, and other factors that require flexibility and integration of appropriate approaches to therapy. In addition to this, child psychotherapy does not occur in a vacuum. To quote Winnicott, "*I once said: 'There is no such thing as an infant' meaning, of course, that wherever one finds an infant one finds maternal care, and without maternal care there would be no infant*" [4]. The same is true for young clients. Therapeutically working with children effectively requires an understanding of the child's world. It often involves working with other systems in the child's life, such as primary carers, family members, school staff, and other professionals.

In addition to the above fundamental differences between adult and child integrative psychotherapy, we argue that there are key global socio-economic and political factors impacting changes to mental health. For example, the recent COVID pandemic resulted in an unprecedented move to online provision of psychotherapy for all ages; in particular, young clients experienced reduced access to broader family support, peers, and a safe and containing school environment for sustained periods. Findings from the NHS Digital survey evidence a rising prevalence of mental illness [5], and a range of acute-onset neuropsychiatric disorders in infants, children, and young people exacerbated by the pandemic [1]. Needs, which may be severe and complex, require skilled integrative child psychotherapists to focus on the individual child within the family in a holistic way rather than focusing on any specific problem(s). The impact of COVID-19 resulted in children and young people being isolated at a critical point in their socio-cognitive development trajectory, with disruption to their education and reduced access to support. After the rise in prevalence between 2017 and 2020, rates of probable mental disorder appear to have stabilised in all groups between 2022 and 2023, at the level of 1 in 5 children and young people aged 8–25 years having a probable mental disorder [6].

The recent NHS Digital suggest that children and young people are at a greater risk of developing mental health issues compared with adults [6]. Many children who are referred for therapeutic support have more than one difficulty, and their needs must be seen in the context of their socio-cultural, economic situation, and educational environment, as well as their family system. The risk of mental health issues increases disproportionately for children and young people from poorer households [7],

with disabilities [8], and those who are carers [9]. We are seeing significant increases in suicidal thoughts (26%), self-harm (25%), anxiety (11%), and depression (9%) among Black, Asian and minority ethnic (BAME) children and young people compared to their white counterparts [10]. The long-term effects of the pandemic also reflected in higher rates of depression and anxiety as enforced social isolation continued [11,12].

It is important to note that routinely collected clinical data is only available through NHS administrative mental health services. Data from services outside the NHS is not routinely shared or accessible [13]. As Grimm et al. suggested [13], the quality of data collection, analysis, and connection between datasets across services and sectors needs to be improved to inform national policy decisions and local service planning and delivery. Systematic collection of robust and granular prevalence data is required to support services to expand in line with need and target support. Improvements in data quality for specialist services must be made, closing data gaps along the emergency crisis care pathway and better data linkage to understand experiences across care pathways. In England, the development of integrated care system (ICS) intelligence platforms—with fully linked, longitudinal datasets across primary, secondary, mental health, social, and community care—will be a significant step forward. However, it is vital that data are collected on support services in schools and services funded by local government and the voluntary sector, which are linked to NHS data. Such platforms will allow ICSs to undertake similar analyses and learn from others.

To fully understand the scale of the challenge to support children and young people's mental health, comprehensive data and analysis are required to identify needs and provide targeted preventative interventions, planning services, and support services. However, because of the unavailability of current data that covers all providers of mental health support, there is a potential underestimation of the number of children and young people experiencing mental health problems across the UK [13]. While available data indicate that the mental health needs of children and young people are growing and services are expanding, too little is known about who receives support and who might be missing out. National prevalence data suggest significant variations in need by sex, age, and socioeconomic deprivation. Data on who is using services are currently only publicly available for NHS specialist mental health care providers and do not cover clients seeking support from charities and practitioners; these data are not detailed enough to capture variation by these characteristics. Thus, while current NHS data indicates that services are not expanding fast enough to meet rising needs, this may be the tip of the iceberg, leaving far more children and young people with limited or no support than current data suggests.

Thus, the mental health support provision within the charity and private sector is operating under the radar of national data collection on CYP mental health with no requirement for routine data collection of young clients' assessments, treatment plans, or outcomes. As this data is missing, there is also little to no transparency about the therapeutic approach that CYP mental health support providers take regarding assessment, evidence-based practice, and potential effective outcomes for young clients in the UK. This suggests a significant risk in ensuring the quality and effectiveness of the psychotherapeutic support offered to children and young people. Therefore, this paper focuses on the role of child psychotherapists working with young clients in the UK and aims to open a discussion towards a common core and unified theory and approach for clinical psychotherapy and assessment for children and young people. The paper emphasises five key challenges facing this profession.

2. Challenge 1: What is child psychotherapy[3]? How do we unify the profession?

Currently, there are two routes to becoming an accredited *Child Psychotherapist* in the UK. One route is completing a 4-year doctorate training programme accredited by the Association of Child Psychotherapists to use the "Child and Adolescent Psychotherapist" title, registered with the Professional Standards Association (PSA). The theoretical model is psychoanalytic. The other route is through the completion of a 4-year master's level training in integrative child and adolescent psychotherapy accredited by the UKCP and also registered with the PSA. The UKCP Standards of Education and Training (SETs) (2019) do not specify a theoretical model as a requirement for the Child Psychotherapist title, and many UKCP-accredited training providers facilitate an integrative approach. This reflects the general principles of the UKCP Child Psychotherapy SETs, which include: (i) recognising the existence of different psychotherapies, known as *modalities*, (ii) being based on various theories, (iii) promoting the respectful understanding of differences and similarities between the theories, iv) be informed by theory and research and be practice-based.

Both accredited routes to child psychotherapy focus on working with infants, children, young people, families, and carers who may present with complex emotional, behavioural, and/or relational difficulties. The therapeutic work may be at an individual level or with parent(s) and/or within families. It may be brief or long-term, and it takes place in a range of settings, including schools, hospitals, local community and voluntary services, residential homes, private practices, and other mental health and social care–related services. It often involves cross-disciplinary communication and coordination with other professional services and systems to ensure an appropriate support team around the child and family.

This raises the question: is there a fundamental difference in how we work therapeutically? Despite the Association of Child Psychotherapists (ACP) presenting a purest psychoanalytic approach to their training and practice, a recent review of research commissioned by the ACP concluded that *"many treatment approaches are now integrative, drawing on the most effective elements of different treatment models"* [14]. Single-modality clinical work with children and young people appears to have been replaced with an integrative approach to psychotherapy in recognition of the developmental and complex needs of children and young people. This is an important point to acknowledge in unifying the profession. However, if this premise is accepted, it raises a further challenge for defining what needs to be included in an integrative approach and how integration occurs.

3. Challenge 2: The need for a common core approach to integrative child psychotherapy and a unified theory of human development

The beginnings of child psychotherapy are generally attributed to Freud's treatment of a little boy (Hans) [15], the psychoanalysis of his daughter Anna [16,17], and the work of Anna Freud, Hug-Hellmuth and Melanie Klein [18–21]. The common factor to these early ideas of child

[3] In this paper, the terms "child psychotherapist" and "child psychotherapy" are used to refer to ACP and UKCP-accredited psychotherapists trained to work with infants, children, adolescents, young people, and parents, individually and within the family. UKCP child psychotherapists are integrative in their approach as reflected in the Standards of Education and Training.

psychotherapy was "*a strong belief in the importance of the child's imaginative life as developed in the matrix of family relationships and as expressed symbolically through play*" [22]. Projective non-directive play was developed as a technical tool for reaching children's unconscious and understanding their immediate emotional and bodily experiences. This has remained an essential medium through which child psychotherapy is conducted [22]. More recently, psychodynamic child and adolescent psychotherapy has become distinct from psychoanalytic child and adolescent psychotherapy, emphasising the therapeutic relationship and continual reference to non-conscious and unconscious processes in shaping the therapeutic relationship [23]. However, these principles do not characterise or inform the therapeutic work of all integrative child psychotherapists. Thus, while the profession has evolved over several decades, it has remained relatively small and specialised and diverse in theoretical underpinnings, principles, methods, and approaches [24]. Generally, child psychotherapists are trained to work with infants, parents, children, adolescents, and families. Some UKCP child psychotherapy trainings include meeting adult SETs, too. The learning journey requires continuing professional development and appropriately qualified and experienced child psychotherapy supervision of all clinical work.

The practice of child psychotherapy has been shaped significantly by theoretical developments, insights into understanding the role of children in families [25], research focused on identifying evidence-based effective practices, as well as changes in society, political, and economic forces that have exerted powerful influences on child[4] treatment. This evolution has led to a proliferation of child and adolescent mental health roles in the UK, a lack of clarity of service provision, and inconsistencies in training requirements for professional practice in this field. Added to the discussions of "what works for whom?" is the confusion of "who does what?". There are 12 core NHS Psychological Professions (see https://www.ppn.nhs.uk/resources/careers-map); however, "integrative child psychotherapist" is omitted.

While the current Scope of Practice and Education[5] (SCoPEd) framework aims to clarify roles and training requirements within the counselling and psychotherapy profession, there is still a lack of clarity regarding the terms of "counselling" and "psychotherapy" in everyday use. There are fundamental differences and a substantial range in breadth, depth, and academic and clinical training levels between different practitioners. The authors argue that the terms "counsellor" and "psychotherapist" are not interchangeable but represent very different theoretical and practice approaches that determine therapeutic work with children and young people, parents, and families with whom we work (see Table 1).

[4] The term "child" is used throughout this paper when referring to children and adolescents up to their 18th birthday, unless additional or specialist emphasis is required. "Young people" refer to clients aged 18–25 years old. "Young clients" refers to children, adolescents, and young people who work with child psychotherapists.

[5] https://www.bacp.co.uk/about-us/advancing-the-profession/scoped/scoped-faqs/.

Table 1. Key differences between child counsellors and integrative child psychotherapists.

	Child counsellors	Integrative child psychotherapists
Training and qualifications	Child counsellors typically have a background in counselling or psychotherapy and may hold qualifications such as a Diploma in Counselling.	Integrative child psychotherapists undergo extensive training at postgraduate level and are required to be in personal therapy and complete clinical hours as part of their training.
	They may specialise in working with children and adolescents but may not necessarily have extensive training specifically in psychoanalysis or psychotherapy or working with children under 12 years.	They are trained in integrating multiple therapeutic approaches, drawing from psychodynamic, humanistic, behavioural, and cognitive theories.
Theoretical approach	Child counsellors often work from a specific theoretical framework, such as person-centred, cognitive–behavioural, or solution-focused therapy.	Integrative child psychotherapists have a broader range of theoretical tools and can adapt their approach based on the unique needs of each child.
	The focus is generally on providing a safe space for the child to express themselves, explore their feelings, and develop coping strategies.	Psychodynamic theories, which explore unconscious processes and early experiences, often play a significant role in integrative psychotherapy.
Duration and depth of sessions	Counselling sessions are usually shorter-term and more focused on specific issues or challenges.	Psychotherapy with integrative child psychotherapists is typically longer-term, allowing for a deeper exploration of underlying issues.
	The approach tends to be more goal-oriented and problem-solving, addressing immediate concerns.	The focus is on understanding patterns of behaviour, emotions, and relationships, with the goal of facilitating lasting change and personal growth.
Regulatory body and professional standards	Practitioners may be members of counselling-related organizations such as the British Association for Counselling and Psychotherapy (BACP).	Psychotherapists may be accredited by bodies such as the UK Council for Psychotherapy (UKCP) or registered with the British Psychoanalytic Council (BPC).
	Adherence to the BACP Ethical Framework is common.	They follow specific ethical guidelines and standards set by these accrediting bodies.

3.1. A common core of integrative child psychotherapy

Drawing on the key values of the UKCP Standards of Education and Training (SET) (2019) and the ACP Competence Framework for Child and Adolescent Psychoanalytic Psychotherapy, there is considerable shared recognition that the child alone is not the problem and is seen in the context of relational, family, social, cultural, religious/spiritual, legal, and political systems that frame their reality. As integrative child psychotherapists, we understand that the foundation for good mental health begins before birth and continues to develop in infancy [26–28]. Thus, theories of human development

must consider the role of maternal emotional states during pregnancy and the critical role cortisol plays in human body functioning, stress response, and reactivity, and how altered cortisol levels relate to psychopathology throughout the lifespan [26].

Generally, integrative child psychotherapists rely on several key theoretical underpinnings to varying degrees: psychoanalytic, self-psychology, attachment, behavioural, cognitive–behavioural, transpersonal, humanistic, existential, Gestalt, eye movement desensitisation and reprocessing (EMDR), and neuroscience-biological evidence-informed theories and family systems theory, to name but a few. The theoretical approaches adopted by each child psychotherapist may depend on several factors, including their training, the needs of their young clients, supervision, CPD, particular interests, assessment of the meaningfulness and usefulness of the ideas and their application, etc. The critical point is that child psychotherapy needs to be integrative, as our theories are incomplete descriptions and only offer a partial understanding of children's needs, motivations, and experiences in the context of their developmental trajectory, in their family relationships, and the therapeutic interaction beyond the processes highlighted for therapeutic work [29]. An attempt to develop a unified common-factors theory or child psychotherapy approach based on a framework of common factors, which integrates ideas from various theories of child development, pathology, treatment, and change, would be a significant undertaking. We need a developmental perspective to weave an integrative approach with theoretical coherence.

The integrative model of pathological development in childhood and inclusive model of therapeutic change in child and adolescent psychotherapy proposed by [29] is based on a contemporary understanding of children's emotions, informed by neurobiology [30], in which every emotion is considered to be a unique subjective experience and a characteristic action tendency. Emotions are evoked by appraisals of events relevant to survival and the relationship between emotions, cognitions, and behaviour. However, Barish's model goes further in integrating emotional regulation while recognising the role of maturation in how therapeutic work needs to match a child's level of emotional maturity in appraising situations and understanding context and the needs and feelings of others [29].

Unlike adults, children and adolescents are in the process of profound developmental change. Therefore, mental health work from a psychotherapeutic approach can be the most suitable form of intervention as opposed to medication or other psychiatric interventions. Unlike adult-trained psychotherapists, child psychotherapists work with their young clients to meet their changing needs and with various significant others in the young client's lives. This necessitates an integrative approach to theoretical, evidence-based interventions across different professional groups and an informed awareness that their young client is still in the midst of psychological and biological growth and development. Young clients are establishing a separate sense of self from important others and acquiring the ego defences and coping skills necessary to master impulses, desires, and conflicts [31]. The focus on the developmental trajectory of the child is essential. Furthermore, a child client is not only in a state of psychological and biological development but is also dependent on their family and influenced by their peer-group relationships and the school context.

Therefore, systemic influences are at play with children and young people when they come to therapy. Integrative child psychotherapists need to consider various systems, such as the family, peers, and school context, as well as other professional services that may be involved in working with the child or family members. Integrative child psychotherapists also need to consider a young client's

multicultural context and their broader relational context, which may be online. The wider political context is also important in the UK, as funding and support for children and young people through the Child and Adolescent Mental Health Service (CAMHS) will be possible if particular thresholds are met, but access may not be immediate. The Care Quality Commission (CQC) published a brief guide to waiting times for community child and adolescent mental health services (CAMHS) in September 2020. They recognised that many young people referred to CAMHS wait many months for treatment, with waiting times varying widely across the country. However, there are mandated national standards for waiting times for young people with psychosis (two weeks) and for those treated in the community for an eating disorder (first contact must be within 24 hours in an emergency, one week if urgent, otherwise four weeks). For others, under the NHS Constitution, no one should wait more than 18 weeks for any treatment. When children and young people are turned away from free mental health services, support is sought from school, community, and voluntary sectors, serviced by private practitioners.

In July 2022, over 689,000 children and young people were accessing CAMHS each month [6]. This reflects an increase of over 100,000 children and young people compared to March 2021 and highlights the unprecedented mental health crisis in children and young people. Thus, it is not surprising that reliance on integrative child psychotherapists in private practice, school-based services, and community-based charities offering subsidised services, as well as remote telephone and app-based and peer-support approaches, are increasing in usage to meet the needs of CYP. To ensure that the quality of services available is appropriate, this paper argues for a common core for integrative child and adolescent psychotherapy, which unites our profession and distinguishes it from other mental health practitioner roles supporting children and young people.

4. Challenge 3: Defining integration in child psychotherapy—common principles and processes

Integrative child psychotherapy recognises that there is not only one therapeutic process in child psychotherapy but many processes [32]. Furthermore, due to the child's significant dependence on parents and teachers for their everyday needs and physical and psychological development, their involvement as part of the child's therapeutic work is essential [31]. Psychotherapy needs to be tailored to each child to support their different needs appropriately and in different ways. Some therapies focus on helping children learn better problem-solving and social skills [29]. Other times, the client may need to develop improved capacities for mentalisation and reflective functioning [33] so they are less overwhelmed by their emotions. Parent and child work may reduce coercive family interactions, promote prosocial behaviours, and strengthen parent–child relationships [29], while trauma-informed practices such as EMDR and cognitive behaviour therapy (CBT) have been identified as evidence-based approaches for overcoming adverse childhood experiences. However, effectiveness may be inconsistent [34].

However, according to Barish [29], the common factor in all these different processes involves finding the source of a child's discouragement and anger and then actively promoting a process to repair emotional injuries, as well as promoting more affirming interactions to arrest malignant emotional processes and vicious cycles of painful emotions and negative family (and peer) interactions. Child psychotherapists need to set positive cycles of emotional health and interpersonal experiences in motion, such as increased confidence and engagement in life and more affirming interactions between parents

and children. To be most effective as a child psychotherapist, the therapist needs to identify and address the core processes that have set in motion unhealthy inner and interpersonal events [29]. If formative pathogenic experiences remain active (e.g., if parents remain angry and critical or if attention and learning disorders remain undiagnosed), the therapy will have limited success.

Children who have suffered complex trauma and have dissociative disorders as a result of in-utero and early adverse childhood experiences (ACE) exposure to distress, violence, and neglect are at high risk of severe medical and psychological consequences in adulthood [35]. However, such adverse conditions may be the origins of "early relational trauma" and "intergenerational trauma transmission", as the infant may have experienced vulnerable and adaptive behavioural patterns [36]. This places infants at risk of maladaptive neurobiological development and negatively impacts their stress-coping systems [37]. Hence, integrative child psychotherapists require a theoretical foundation for treatment that combines human development, attachment, neuroscience, personality development, and psychotherapy. Schore presented neuroscientific research to support his neurobiological model of intersubjectivity of psychotherapeutic interaction and affect regulating functions of attachment relationships [27,37,38]. The integration of these fields of expertise provides an essential understanding of how adverse events contribute to maladaptive development and mental health issues and enables therapeutic work at a deeper level.

Adler-Tapia and Adler-Tapia and Settle provided a developmentally grounded and integrative clinical approach for working with children with complex trauma and dissociation to help them develop a coherent sense of self and integrated personality while reprocessing attachment trauma and abuse [39,40]. They integrated dissociation theories with development theories to explore how attachment impacts dissociation, including recent findings in neurodevelopmental trauma and neurobiology. Adler-Tapia argued that Piaget's theory of assimilation and accommodation is not sufficient to explain how children cope with overwhelming traumatic experiences and that a third process of dissociation is required to act as a coping mechanism [39].

This approach highlights how the development of attachment theory and the proliferation of research has led to new ideas and applications to child psychotherapy, some of which rest on more solid theoretical and research foundations than others [41]. Attachment is a significant developmental construct and plays a role in every child's psychotherapy assessment, formulation, and therapeutic approach. However, it is important that it is not considered the only focus but should be combined with other therapeutic needs and methods [42]. Object relations models of dynamic conflict stress the conflictual nature of "closed systems" and unintegrated internalised object relationships [43,44], while self-psychology models stress essential disruptions in the development of an integrated and benign sense of self [45]. Child work requires understanding dynamic conflicts and how the conflict may be interwoven and interplay with cognitive, behavioural, and interpersonal developmental needs.

4.1. Mechanisms of change

Mechanisms of change try to explain the steps responsible for therapeutic outcomes that set in "motion positive cycles of increasing self-confidence and supportive family relationships" [46]. These may be fostered by ten key principles that include interest, empathy, repair, problem-solving, emotional regulation, encouragement, play, sleep, helping others, and limits and discipline [29].

However, it is important to distinguish *mechanisms* of change (e.g., safety and play, community and family capacity building, therapeutic rapport) from *content* of change (e.g., empathy, repair, problem-solving, emotional regulation, problem-solving). Research has demonstrated the significance of a sensitive and adapting therapeutic alliance and the role of play and playful stance in child psychotherapy as essential mechanisms of change [47,48]. The importance of family and community capacity building may be achieved through parental collaboration [49].

Reframing Barish's ten basic principles of therapeutic change to eight core mechanisms of change [46], each linked to a key therapeutic premise and content of change (see Table 2), may provide a useful common ground for fostering mechanisms of change. As Barish states [46], effective therapy does not follow a prescribed form or duration or manualised approach. Instead, the duration is determined by the severity and "stuckness" of the pathogenic processes and by the willingness of the children and parents to participate.

Table 2. Mechanisms of therapeutic change.

Mechanisms of therapeutic change Principles are overlapping, cyclical, and synergistic		
Mechanisms of change	Content of change	Underlying premise
Safety	Repair	Infants, children, and young people are adversely affected by emotional, psychological, and/or physical difficulties and/or neglect
Containment Therapeutic alliance and rapport	Emotional regulation	Recognise the child's right to self-determination, within the reasonable constraints of their need for safety, protection, and care, in keeping Safeguarding and Child Protection legislation.
Child-led		The work is non-directive and child-led, it can be open-ended or for a defined period.
Child-focused	Problem-solving	We work in a non-discriminatory way, compliant with child's individual human rights and the 1989 United Nations Convention on the Rights of the Child.
Strength-based	Hope	The aim is to promote long-term mental health
Community and family capacity building Limits and discipline	Collaborative with family and significant others	The focus of the work can be individual children, young people, parents, infants and parents, whole families, or groups.
Play	Engaging	The child has the right to unimpeded growth and development.
Safe environment to express emotion	Sensory and neurologically based	The child has the right to express their developmental needs.

Emotional processing in psychotherapy has been a reliable predictor of positive psychotherapy outcomes for adults and across modalities [50–53]. Although the depth of emotional processing is a likely change moderator in child psychotherapy, there has been less empirical research on this with children [54].

However, Fonagy and Target argued that a child's ability to develop healthy mirroring is central to developing a secure attachment and provides the foundation for their reflective function and later emotional regulation [55]. Where this is not developed through a healthy relationship with a parent or other caregiver, this may be developed as a therapeutic process and mechanism of change, i.e., as a mentalisation-based intervention built on Schore's concept of preverbal affect regulation: the therapist's capacity to attune prosody [27], with facial expressions and body language, becomes the reparative object to unstick the pathogenic process. Slade suggested that it is important that a therapist engages with and mirrors the child and simultaneously maintains a separate sense of self and reality, fostering the child's development of emotional and self-awareness through the therapist's symbolic representation of them [56].

Over the past decade, affect-regulation and mentalisation-based treatment (MBT) approaches have been developed specifically for children, adolescents, and families, with tentative support from systematic reviews of MBT applicable to both children and families, despite methodological shortcomings [57]. This therapeutic framework and evidence underscore the importance of supportive and empathic interactions in child psychotherapy while integrating the following process mechanisms:

1. Engagement and mirroring to facilitate a child's understanding and processing of emotions and emotional development.
2. Maintaining a separate sense of self to allow the child to learn about their own emotions while respecting the individuality of the therapist.
3. Symbolic representation to model healthy emotional responses and interactions while guiding their developing emotional awareness and regulation.
4. Secure attachment and reflective functioning to develop a secure base from which to explore the world with a greater understanding of their own and others' emotions and thoughts.
5. Development of emotional regulation to navigate social interactions and manage emotions effectively.

The use of the therapist as a developmental object, as opposed to a transference object, may be key to the mechanisms of change in child psychotherapy, according to Schmidt Neven [58], who discussed the need to understand emotional milestones as fundamental for effective practice. Assessment and therapeutic communication with children, parents, and young people do not commence with uncovering pathology but with understanding the meaning of their behaviour. Focusing on development enables us to identify what constitutes the unifying developmental experience for all children and young people rather than what sets them apart. Schmidt Neven's schema for providing a developmental scaffold for effective practice posits that [58], as each child faces the developmental tasks arising through the stages and phases of development, parents similarly face associated developmental tasks and risks associated with meeting and navigating these developmental milestones. However, this schema relies on several assumptions about child development: (i) each stage of development is associated with appropriate behaviours; (ii) parents are not made but become parents through trial and error; (iii) development is a reciprocal process and mutually transformative; (iv) fathers and mothers are essential in a child's development; (v) all development is predicated on the importance of relationships; (vi) satisfactory attachment and bonding are essential drivers for emotional development and cognitive and brain functioning.

The quality of the environment where children and adolescents grow up shapes their well-being and development. If early negative experiences in homes, schools, or digital spaces, such as exposure to domestic violence, the mental illness of a parent or other caregiver, bullying, and poverty, increase the risk of mental illness, the experiences of war, armed conflict, and political violence have extensive detrimental effects on the mental health of children and adolescents. PTSD, depression, and anxiety disproportionately affect those affected by war and violence, as well as cognitive, emotional, and behavioural concerns, including externalising and internalising behaviours. Bosqui and Marshoud reviewed underlying mechanisms of change [59], rather than intervention-specific effectiveness, to help connect theory to practice by identifying key therapeutic processes that transcend the diversity of models, approaches, and techniques that could be applied across service settings and socio-political and cultural contexts. The review found a conceptual role of safety and play, community and family capacity building, and focused support including stress management skills, problem-solving, emotional regulation, and altruism. The mechanism with the best evidence within specialist support was therapeutic rapport, operationalised as reflective practice, a safe environment to express emotion and no moralistic or judgemental behaviour. However, the overall quality of evidence on interventions aimed at limiting the psychological effects of war on children is limited in scope and quality (lack of control groups, poor clarity of theoretical model or intervention), resulting in a large theory-practice gap.

Working therapeutically with children of different ages requires an integrative perspective to allow the therapist to see the array of interwoven and multi-dimensional aspects of a child's development that need to be considered as part of the formulation and assessment process and tracked for progress as part of the therapeutic work [31].

Stern, Tronick, Sander et al., of the Boston Change Study Group (1998) set out in the mid-90s to explore the non-specific factors in psychotherapy; in other words, which factors in the psychotherapeutic context are effective, but not part of a specific method or among elements, that the psychotherapist emphasises or pays particular attention to in the meeting with the client? Sander highlighted that the source of the child's self-regulation process is the synchronisation between parent-child dyads through microscopic moments of meeting [60]. Through these "present moments", the child develops self-regulating processes by connecting with a more mature and better-regulated nervous system. Importantly, these moments also occur in the psychotherapy process. "Present moments" are when the therapist and the child display authentic, personal responses. It can be assumed that they both have a mutual experience of sharing the same mental landscape, which happens with carer–child interactions as "moments of meeting" [61,62].

In the same way that neural circuits are modified by current experiences, a successful therapeutic process, according to Bentzen and Hart [63], reorganises and integrates the neural circuits shaped by appropriate regulation strategies. They suggest that *microscopic moments of meeting* leave their marks in the neural circuits, modifying the micro-anatomy of the child's brain [63]. As the need for emotional attachment is innate and intrinsic, when this fails to happen, i.e., when there is no emotional attunement, there is no development.

Hence, child psychotherapy—or any psychotherapeutic process—requires methods that are more aimed at attunement to the more deeply seated subcortical structures [63]. Emotional development and maturation involve building attention control, arousal regulation, and affective attunement. Childhood and adolescence are critical stages of life for mental health. This is when rapid growth and development

occur in the brain. Children and adolescents acquire cognitive and social–emotional skills that shape their future mental health and are important for assuming adult societal roles. Thus, the key is to meet the child in their zone of proximal development [64]. However, parents cannot provide good enough care and support their child's development if they have not been supported in their development [4]. Emotional development occurs through deep synchronisation processes and affective attunement [45].

Following Barish [29], our basic human motivation, especially in childhood, is to seek and preserve good feelings. This motivation animates and guides our relationships and is a common mechanism of therapeutic change across different treatment modalities. From this perspective, an essential therapeutic mechanism of child psychotherapy is hope. Barish argued that hope is the first integrative psychotherapy concept shared by cognitive therapy [46], CBT for depressed adolescents, psychoanalysis, and dialectical behaviour therapy. However, although this may be a necessary premise of psychotherapy, is it sufficient for effective outcomes?

To distinguish the profession of integrative child psychotherapy from other practitioners and avoid the approach of "anything goes", a model or guiding framework is needed that is built on broad but sound theoretical principles supported by evidence from research and practice to direct and shape excellence in psychotherapeutic practice, which applies across different client needs, contexts, cultures, and agreed outcomes. This necessitates a common language to facilitate discussion, research, evidence-based practice, and effective and meaningful communication across the field of integrative child psychotherapists: with our clients, their families, and others, including those in education, social services, and politics.

This makes identifying a common core approach to integrative child psychotherapy essential for the benefit of children's mental health, public interest, access to services and client choice, policy developments, and directing research funding to inform evidence-based practice. However, this approach needs to be supported within the UK's current socio-political and economic climate and beyond.

5. Challenge 4: Case formulation and assessment of children and young people's mental health needs

"…everything we need to know about the client is contained in the first session, if only we had the wit and understanding to see it" [65].

Alvarez emphasised the need for psychotherapists to carefully observe and assess how early experiences of integration and fragmentations and different states of unintegration, under-integration and, disintegration manifest in behaviour, emotions, and relationships to understand a client's internal world and psychological functioning, and inform the therapeutic process [66].

Any child's problems need to be understood against a comprehensive assessment of their biological, behavioural, affective, cognitive, and neurological developmental trajectories. Developmental psychology is an essential bedrock of any integrative child psychotherapist to evaluate a child's expressions in the light of developmental expectations and the child's relationship with those in a parental role. It is key to providing context to the child's developmental picture and insight into the child's core sense of self and a core experience of the self as related [31]. Emotional literacy work with young clients aids their ability to recognise, label, and express their internal affective experiences

before they can be taught how to understand and use their reactions to different experiences and develop their emotional intelligence and ability to empathise with others.

Integration in the psychotherapeutic process already starts with the assessment to allow a transtheoretical analysis of all aspects of the child's presenting needs—their inner conflicts, emotional states, and behavioural, cognitive, and systemic aspects of their world all need to be taken into account to provide a coherent therapeutic understanding of the child's needs and to formulate an appropriate approach, which may involve a range of tools and the inclusion of significant others as part of the intervention(s). The work requires clinical sensitivity and sensitivity to multicultural contexts encountered with young clients, including the impact of the recent Black Lives Matter movement and children displaced from their homes due to political unrest or war. The effect of COVID on children's mental health is still unfolding, and concerns and actions needed to address climate change to ensure our children inherit a healthy, sustainable world are just some of the key contextual, wider socio-economic and political factors that need to be considered in child psychotherapy, because a child is not an island.

Schmidt Neven highlighted the core principles of assessment and therapeutic communication with children, parents, and families [58]:

1. The recognition that all behaviour has meaning and is a communication.
2. The centrality of advocacy for the child and young person.
3. Understanding and working with the parental and family context—how the child "speaks" with the family.
4. Promoting a therapeutic process for children, parents, and young people that provides containment and empowerment.
5. Taking care of ourselves as professionals.
6. Working towards a broader conception of child and family wellbeing.

Wachtel (1977; cited by [31]) challenged the idea that psychodynamic, behavioural, and cognitive models are incompatible. Instead, he advocated a directive, action-oriented psychodynamic approach that considered the importance of early experiences but had a strong present orientation. The inner life of individuals—their unconscious wishes, fantasies, and ideas representing early experiences—interact with present experiences. This includes the demands and stresses of being within a family system.

Gold (1992; cited by [31]) summarised the importance of this circular, interacting model and expanded it to a model of multiple causation in which "individual, family, and the socioeconomic and political context are construed as mutually influencing and influenced by each other in an interlocking system of feedback circles and loops". The formulation from a standard interview is there to understand the presenting problem, with detailed, concrete illustrations, and a general history of the problem and the client (Fitzpatrick, 1993) and covers all aspects around:

1. What is the problem(s)?
2. What caused it? Precipitating factors?
3. What maintains it? Perpetuating factors?
4. What is the desirable outcome(s)? (How will we know when we have finished?)
5. What are the desirable roles of both the client and the therapist?
6. What are the client's preferred methods of psychological change?

7. What is preventing the client from changing?

From the information gathered from the initial assessment sessions, a formulation can be developed, which includes an understanding of the intrapsychic and interpersonal factors of individual problems and the role played within the family dynamics for maintaining the issues as well as strengths that can be drawn on to facilitate the therapeutic process.

Working with children demands at least some contact with parents and/or school staff if working within the school context. Older adolescents may refuse involvement with their parents and/or school staff. Gillick competence must be respected in such cases, as their cognitive and emotional separation from their parents allowed them freedom of choice [67].

6. Challenge 5: What evidence counts for evidence-based practice? Evidence-based and outcome research for integrative child psychotherapy

The outcome research focused on evaluating the efficacy of child psychotherapy is not as extensive, well-funded, or developed as the evidence base for psychotherapies with adults. The evidence base for child psychotherapy might lead us to think that there are pure forms of psychotherapy that are most effective for working with particular presenting problems. Midgley et al. provided a recently updated systematic review of the evidence base for psychoanalytic and psychodynamic psychotherapy with children and adolescents, commissioned by the ACP [14]. This follows a need for more empirical research on bona fide integrative therapy for children [68]. This may be because while therapeutic work with children may be integrative for pragmatic reasons, it is rarely identified as integrative (Chorpita et al., 2002; cited by [68]). In addition to this are the research skills and funding needed to carry out randomised controlled trials (RCT) research [14]. The academic, professional, and political focus on an adequate evidence base for child psychotherapy has resulted in the systematic review by Midgley et al. [14], identifying 37 papers and reporting 32 distinct research studies aimed at evaluating the effectiveness of different types of psychodynamic child and adolescent therapy for diverse populations. However, five of the studies were RCTs (i.e., adopting what is considered by many to be the most rigorous methodology for treatment evaluation). Still, findings overall showed beneficial effects on various standardised outcome measures and, in some cases, sustained improvement at follow-up.

Overall, the review by Midgley et al. concluded that the majority of research with children, mostly of primary school age, with emotional disorders respond well to psychodynamic therapy [14]. Similarly, young people with moderate to severe depression have at least equally good outcomes in psychodynamic therapy as in other well-supported approaches such as CBT and family therapy. Findings from two studies suggest that contemporary psychodynamic therapy, such as mentalisation-based treatment, may be effective for treating self-harm, but further research is required to compare with a wait control or specific alternative psychotherapy such as CBT. For anxiety disorders, the evidence so far suggests that psychodynamic therapy, even short-term (<30 sessions), is effective, with outcomes maintained at a 6-month follow-up.

However, research into the efficacy of psychotherapy focuses on evaluating the outcome of single modality, theoretically coherent, manualised approaches to specific presenting needs (e.g., depression or anxiety). When working with children, there are often multiple difficulties to understand within the

context of the child's world—their family, social network, community, and the wider socio-economic and political environment. While RCT-designed research provides definitive evidence of what works within precisely defined and controlled experimental situations, perhaps we should also ask, "What are the most important principles and processes that inform effective support for complex cases?" given the current diversity in approaches, rising needs, and empirical hiatus.

For example, evidence suggests that psychodynamic therapy is one of several effective psychotherapies for eating disorders. However, recent efficacy studies of psychodynamic therapy suggest that psychodynamic therapy may encapsulate different ideas of psychodynamic practice with children. Research by Chirico et al. (2019; cited by [14]) investigated the efficacy of focal play therapy with 17 children aged 2–5 years experiencing "eating and evacuation" disorders. The treatment involved weekly alternate play sessions with the child and their parents together, and sessions with parents only. While the study design, with measures taken from the first six weeks, and its small sample limit the conclusions that can be drawn, there is evidence of a positive parent–therapist alliance and potential for remission in child symptoms. Overall, data from the Midgley et al. review suggests that psychodynamic psychotherapy is an effective approach for emotional disorders in children [14]. However, the nature of psychodynamic psychotherapy may not be a pure psychodynamic approach.

Similar positive findings are reported for research investigating psychodynamic psychotherapy for behavioural disorders. However, dropout rates tend to be higher for children and young people with externalising disorders, reducing the overall evidence of effectiveness.

Studies examining the impact of psychodynamic therapy on children experiencing various forms of trauma or early adversity suggest promising findings, including with children in foster care or who have been adopted. It is important to note that the studies included in the review were not identical in their psychodynamic approach. Interventions were delivered to parents only, as well as to the child and parent together. The treatment approach in one study was based on trauma theory, attachment theory, and psychodynamic theory; in another, the psychodynamic milieu therapy was evaluated, and others have included evaluations of mentalisation-based therapy or comparisons with psychoeducation. Overall, results show potential for increased well-being for children and decreased stress for carers. However, research studies are limited, and more experimental studies with larger samples are required and [14], more importantly, highlight the absence of a pure psychodynamic approach adopted in child psychotherapy.

The common core of the psychodynamic approach with children and young people, as illustrated through evidence-based research, suggests an integrative approach is already being adopted; for example, the inclusion of mentalisation-development treatment [69] with parents and/or the young client itself is integrative as it draws on core ideas of cognitive psychology, attachment theory, and Bion's theory of thinking [70,71].

In terms of the impact of treatment length (e.g., over 30 months) and intensity (e.g., more than one therapeutic session per week) on more effective outcomes, overall, the research reviewed by Midgley et al. leads to tentative conclusions based on a lack of research [14]. Similarly, insufficient focused research on the impact of client age on treatment outcome means that any indications that younger clients may show more significant improvements than older children may merely support the principle of early intervention, as opposed to the type of therapeutic intervention.

Providing parallel parent work is a core element of child psychotherapy and is supported by Novick and Novick as an essential factor in determining positive outcomes [72]. However, more research needs to be conducted to evaluate the parent work's contribution to child psychotherapy's effectiveness [14].

Overall, research on the efficacy of child psychotherapy outcomes, reviewed by Midgley et al. [14], highlights the need for significant funding as part of a programme of evaluations to determine the contribution of specific elements of child psychotherapy on effective outcomes. To achieve that, there is a need to define the specific core elements of child psychotherapy in practice, as opposed to the theoretical narrative of psychodynamic child psychotherapy, which is presented.

Pioneering examples of such research include capturing interactive and autoregulatory strategies in therapeutic practice through video-microanalysis [73,74] providing valuable theoretical and conceptual connections with insights into critical aspects of therapeutic action as an essential research focus and methodology. Evidence of psychological sequelae of trauma from a longitudinal study of 45 mothers from low-income families assessed through coded observations of maternal–infant interactions, maternal history of early trauma, and analysis of in-depth interviews, underscore the critical role of early intervention and therapeutic support for children and families at risk of developing insecure and disorganised attachment patterns through attachment focused therapy and play therapy [75–77].

Similarly, the evidence base for improving infants' and parents' mental health through parent–infant psychotherapy has led to a growing research focus on outcomes, which have been further evaluated as part of systematic reviews by Sleed and Bland [78], Barlow et al. [79], Barlow et al. [80], and Huang et al. [81]. These reviews suggest that mother–infant psychotherapy can be effective for maternal depression [81] and secure attachment [82], alleviating a range of maternal and infant mental health and development problems and improving the quality of the relationship between parent and infant [78]. However, the field of parent–infant psychotherapy, although originating from a psychoanalytic paradigm, has developed through several therapeutic modalities, borrowing concepts from behaviourism, systems theory, social networks, and paediatrics, which have been modified to work with a new population and converging to develop unified psychotherapy, competently practised, and equally effective [83–85]. The commonalities among the different approaches to parent–infant therapy, including the non-analytic approaches, include first the brief nature of therapy, lasting between 3 and 12 sessions, to focus on the difficulties created by the new current relationship between mother and infant, to reduce parental projections onto the infant. A second common feature that Stern (1995) identified is the use of positive transference, and as Barrows points out [84], much use is also made of countertransference. The third common feature noted by Stern (1995) [83], is for the therapist to function as a "dynamic disconnection between past representations and present realities" (Hopkins, 1992; cited by [84]).

Within the wider field of child psychotherapy, parent–infant psychotherapy benefits from evidence drawn from neuroscience. Several studies have demonstrated the beneficial effects of SSC practice on preterm and full-term infants (e.g., enhancing the physiological, emotional, and cognitive regulatory processes) [86]. However, in an attempt to understand the underlying neurobiological mechanisms, a systematic review by Ionio et al. suggested how skin-to-skin-contact in mother–infant relationships regulates child stress [87], as measured by biological indicators such as the autonomic nervous system, heart rate variability, cortisol, and oxytocin, which provides potential evidence in

support of Bick's psychoanalytic notion of the skin as a primary maternal container supporting the growth of the baby's psychic skin and holding together parts of the self [21], which have as yet no coherence. The difficulties experienced by infants and children with early histories of neglect and maltreatment highlight the significance of touch and contact as a necessary human experience related to socio-emotional, physical, cognitive, and neurological development in childhood [88]. Furthermore, as Ionio et al. pointed out [87], the COVID-19-related restrictions on hospital procedures caused additional distress for pregnant women; in many countries, women were requested to attend all prenatal appointments alone, and in some countries, women were even asked to be alone during birth. In sum, this lack of contact could elevate the level of prenatal psychological distress for both women and their babies. The challenging and complex work of child psychotherapists who specialise in therapeutic work with parents and infants will be in increased demand.

Notably, many child psychotherapists already integrate other evidence-based psychodynamic, humanistic, and CBT principles and approaches (see Table 3) within their practice, informed by attachment theory and neuroscience, and adopt methods from creative therapies [89]. In practice, an integrative approach offers therapists more ways to intervene with children and families and more opportunities to choose at what point in a vicious cycle of events to adopt particular interventions [29].

However, a key question is what is effective psychotherapy? Rustin and Rustin argue that the demand for evidence-based research in child psychotherapy has focused on treatment outcomes, disregarding other research aims [71]. This includes the reduced focus on identifying processes and mechanisms of change and core principles of child psychotherapy. In effect, the political approach to child and adolescent problems and the quantitative paradigm of "evidence-based practice" can result in a deficit view of the child, a concern with treating and eliminating distinct malfunctions and devaluing the understanding and capacity of the children and young people and their parents in supporting their mental health [58]. However, before the move to RCT research as the gold standard for causality evidence-based practice, psychotherapy relied on clinical case studies and vignettes, to explore, examine, and illustrate effective practices through a deep exploration into subjective experiences of change, although not measured quantitatively. Qualitative methods and non-RCT experimental design methodology offer a range of sound approaches to building evidence-based understanding of therapy processes, outcome evaluations, and narrative explanations underpinned by theoretical and conceptual ideas [90,91].

Given the need for integrative child psychotherapists to tailor their therapeutic work to the individual needs of the child, this places clinical work in a central position for therapeutic development. Case studies and vignettes provide an essential vehicle for sharing understanding and discussing discoveries drawing on the theoretical foundations behind the work and the processes and mechanisms fostering progress. However, the findings are difficult to verify and generalise, and present ethical issues regarding consent and confidentiality. However, the focus on measuring the efficacy of child psychotherapy interventions needs to be balanced by meaningful, in-depth accounts of experiences within the therapeutic relationship with the child, parents, and other professionals. In this way, the field of child psychotherapy may be enhanced by rich insights from practice-based research.

Table 3. Evidence-based approaches to working with children and young people.

	Description	Evidence
Eye movement desensitisation and reprocessing (EMDR)	A therapy that can be applied for both adults and children in the case of PTSD. A number of RCTs have been conducted with children and adolescents with trauma-associated symptoms, showing significant reductions in presenting problems. NICE guidelines recommend EMDR for children and young people aged 7–17 years with a diagnosis of PTSD or clinically important symptoms of PTSD who have presented more than 3 months after a traumatic event only if they do not respond to or engage with trauma-focused CBT [102]. The efficacy of EMDR therapy has also been studied in children and adolescents.	Barron et al. [96]; Moreno-Alcazar et al. [97]; de Jongh et al. [98]; Rodenburg et al. [99]; Beer [100]
Cognitive behaviour therapy (CBT)	A psychological intervention for mild, moderate, and severe depression [102]. Several meta-analyses have shown that effect sizes are small to moderate when utilised as a treatment for children and adolescents, although IPT has not been shown to be more effective than CBT for adolescents. A recent systematic review and meta-regression analysis found that CBT is effective for youths with depression, and effects may improve when CBT contains the components of behavioural activation and challenging thoughts, and also when caregivers(s) are involved.	Oud et al. [102]; Hetrick et al. [103]; Klein et al. [104]; Yang et al. [105]
Mentalisation-based interventions	A theory of mentalisation [69] has developed based on attachment theory, which provides the basis for mentalisation-based interventions with children and young people. This approach focuses on developing individuals' capacity to understand their own and others' feelings, to be able to respond with empathy, and to self-reflect and engage in symbolic thinking. The capacity for mentalisation, however, rests on an ability to affect regulation, which requires support from others to support congruent and marked mirroring of feelings to help young clients identify and name their feelings and manage boundaries between themselves and others. Regulation and management of feelings is a key focus of the therapeutic intervention.	Byrne et al. [57] for systematic review
Sensorimotor psychotherapy (body-oriented psychotherapies)	Recent developments in neuroscience have informed our understanding of "neuroaffective development", which also aligns with attachment theory.	Bentzen and Hart [63]
Creative therapies (Art, Drama, Music, Play)	Creative therapies foster meaningful relationships between therapists and vulnerable children, which are explored through the concept of communicative musicality and creating rhythms of connection. Examples from music therapy, trauma, dance and movement therapy, psychobiology, dramatherapy, counselling, play therapy, and education are presented by therapists such as Peter Levine, Daniel Hughes, Stephen Porges, Dennis McCarthy, etc.	Osborne et al, [89]

7. Discussion

Integrated treatments are not new to child therapy [92]; child practitioners have used techniques and procedures from various theoretical sources in their clinical work with children for some time [93]. Unfortunately, only some of these integrated treatments have been evaluated, and many probably still need to be replicated, and a key issue of how to evaluate combined treatments remains [92]. This is

not to say that integrated treatments are not useful. Instead, it points to the fact that child practitioners have typically been forced to construct integrated treatments based on the pragmatics of specific cases rather than on empirical evidence supporting the effectiveness of particular treatment combinations. Hence, is there enough evidence of therapeutic equivalence for a "common-factors approach" to integrative child psychotherapy? Or is a framework for a unified theory and approach to child psychotherapy based on principles and common effective elements needed?

The "common factors" hypothesis for psychotherapy integration is proposed to explain the therapeutic equivalence found from outcome research, which mostly focuses on psychotherapy outcomes with adults. For example, Laska et al. argued that [94], given the equivalence in comparative treatment outcome literature, the evidence for empirically supported treatments (EST) suggests that common factors to therapy in general or evidence-based practice exist.

However, Lambert and Ogles (2014) disagreed and argued that while the evidence base for many therapies suggests they are equally effective [95], *"it is a mistake for government organisations, clinical training programs, and managers of mental health outcomes to overemphasise or attribute the positive outcomes of psychotherapy to the use of specific techniques with specific disorders, and thereby rely so heavily on clinical trial-based ESTs as a means of improving patient outcomes in routine care" [95].*

The question is, are different therapeutic approaches equivalent in client outcomes? Do we have the right research and evidence base in child psychotherapy to build a common-factors approach for child psychotherapy? In adult psychotherapy, a common factor identified across all therapies as key is the therapeutic alliance—the relationship between therapist and client. Given the complexity, diversity, and challenges of psychotherapy with children, do we have sufficient evidence to suggest that there is therapeutic equivalence across different approaches?

While a therapeutic alliance is both a necessary and sufficient mechanism for therapeutic progress in adult and child psychotherapy, the nature of the therapeutic alliance between a child psychotherapist and their young client fundamentally differs from that of an adult psychotherapist and their adult client. Schore's research highlighted the significance of the caregiver–infant relationship in informing effective therapeutic alliance with children [37], recognising the importance of safety and trust, understanding attachment patterns, addressing dysregulation, repairing ruptures, and facilitating the client's emotional regulation and interpersonal growth. The integrative child psychotherapist may be the safe, non-judgemental, supportive, and playful relationship they experience and require. However, further research is needed to address the question of equivalence [31]. This may require a detailed analysis of contingent moment-to-moment therapist–child interaction to understand further dissociative attunement, rupture, and repair following the work of Beebe et al. [74].

8. Conclusions

Child psychotherapy is integrative in theory, practice, processes, mechanisms, and principles. The broader socio-economic and political context of the child's world, including those forces currently shaping children's mental health services, needs to be acknowledged to allow recognition and to confront the barriers to "integration" of the two streams of training in the UK. The discipline and practice of child psychotherapy face key challenges and developmental tasks, which in many respects

would benefit from an appropriate evidence base. However, the nature of the evidence base needs further consideration.

Author contributions

This paper was prepared by all three authors who have contributed to the focus and content of the paper, and all authors have read and approved the final version of the manuscript for publication.

Use of AI tools declaration

The authors declare they have not used Artificial Intelligence (AI) tools in the creation of this article.

Conflict of interest

The authors declare no conflict of interest.

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