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MAJOR RESEARCH PROJECT

EXPLORING HEALTH VISITORS' ROLE AND EXPERIENCES WHEN WORKING WITH PERINATAL MENTAL HEALTH AND PARENT-INFANT RELATIONSHIP DIFFICULTIES

Section A: Health visitors' role in supporting women experiencing perinatal mental health problems (PMHPs): what do they have to offer? A review of the literature

Word count: 7, 565 (plus 386 additional words)

Section B: How do health visitors make sense of their experience of talking about difficulties with the parent-infant relationship? An Interpretative Phenomenological Analysis

Word Count: 7, 401 (plus 670 additional words)

Section C: Appendix of supporting material

TOTAL WORD COUNT: 14, 966 (plus 1056 additional words)

A thesis submitted in partial fulfilment of the requirements of Canterbury Christ Church

University for the degree of Doctor of Clinical Psychology

June 2020

SALOMONS INSTITUTE

CANTERBURY CHRIST CHURCH UNIVERS

Acknowledgments

Firstly, I would like to thank all the participants who agreed to take part in the study. I am incredibly grateful for their time and willingness to share their experiences with me.

Thank you to my supervisor Alex Hassett for your support and guidance throughout the process and to my manager Trish Joscelyne for the much-needed containment you both gave me! Thank you also to Virginia Lumsden who offered additional support and supervision.

I would like to thank my partner Manny for his ongoing support, encouragement and continual reminders of ‘You will get through it, you always do’. Thank you also to my friends for their support and understanding.

Summary of the MRP portfolio

Section A provides a review of the empirical literature of health visitors' role in supporting women with perinatal mental health problems (PMHPs). The review outlines what interventions health visitors can offer as well as the effectiveness of these interventions. Other key areas of their role are outlined, for example, making referrals and providing support to women experiencing PMHPs. Papers are reviewed in light of their methodological strengths and limitations, and clinical and research implications are discussed.

Section B describes a qualitative study that explores how health visitors make sense of their experience of talking about difficulties with the parent-infant relationship. Ten semi-structured interviews were completed and analysed using Interpretative Phenomenological Analysis. Five superordinate themes and related sub themes are outlined and discussed in relation to existing literature. Limitations, clinical implications and future research are outlined.

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SECTION A: LITERATURE REVIEW

Health visitors' role in supporting women experiencing PMHPs: what do they have to offer? A review of the literature

WORD COUNT: 7565 (plus 386 additional words)

A thesis submitted in partial fulfilment of the requirements of Canterbury Christ Church University for the degree of Doctor in Clinical Psychology

June 2020

SALOMONS INSTITUTE

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Abstract

Background: Perinatal mental health problems (PMHPs) are associated with significant difficulties for women, their infants and the wider family. Health visitors are in optimal positions to assess and offer interventions to women experiencing PMHPs.

Aim: This review aimed to carry out a systematic search of the literature to understand what role health visitors play in supporting women experiencing PMHPs**.**

Design: Six databases were searched systematically and reference lists of retrieved papers were scanned**.**

Findings: Twenty-nine papers matched inclusion criteria. Health visitors were found to offer interventions such as listening visits and interventions incorporating cognitive behaviour therapy (CBT), which were found to be effective in reducing symptoms of depression. Referral practices varied, however, referrals to GPs were most common. Whilst health visitors generally viewed their role as supporting women, they did not want to be viewed as counsellors. Finally, a need for further training was highlighted.

Clinical and research implications: With adequate training and support, health visitors could offer interventions such as listening visits or CBT informed sessions. Health visitors could also be trained into more specialist roles. A role for psychology exists in supporting this process, as well as offering more supportive spaces to health visitors.

Key words: health visitor, public health nurse, perinatal mental health, early intervention

Introduction

Prevalence of PMHPs

Pregnancy is associated with many changes for women, which can affect their emotional wellbeing (Alderdice et al., 2013). Psychological difficulties in the perinatal period are common and whilst postnatal depression (PND) is often referred to (Rance et al., 2016), women may experience a range of difficulties including obsessive compulsive disorder (OCD), post-traumatic stress disorder (PTSD) and psychotic disorders (Paschetta et al., 2014).

The term perinatal mental health problems (PMHPs) is widely used to describe difficulties with mental health and mood during the perinatal period (with some defining it as covering pregnancy and up to a year after birth) (Austin et al., 2008). For some women, difficulties may arise for the first time, or pregnancy may act as a trigger for women with previous mental health difficulties (Goebert et al., 2007). Estimates indicate that around 15% of women will experience depression or anxiety during the perinatal period (Khan, 2015). In relation to more serious mental illness (SMI) such as postpartum psychosis, prevalence rates are suggested to be one or two for every 1000 women (Sit et al., 2006). Risk factors for PMHP's include previous mental health difficulties, limited social support as well as absence of a partner and difficulties in the couple's relationship (Johanson et al., 2000; Leigh & Milgrom, 2008; O'Hara et al., 2014).

Impact of PMHPs

It is now understood that difficulties with PMHPs are linked to subsequent impairments in relation to children's development and psychological health (Stein et al., 2014). Problems with the mother's mental health may have an impact on the infant's social, emotional, behaviour and cognitive development (Kurstjens & Wolke, 2001).

The experience of PMHPs may affect the mother's ability to bond with her baby during pregnancy (Misri & Kendrick, 2008), but also have significant consequences on the relationship post-partum (Hipwell et al., 2003). A meta-analysis looking at how mothers with PND interacted with their infants highlighted a number of difficulties. These included a lack of engagement and warmth toward their baby, as well as reduced rates of play (Lovejoy et al., 2000).

Increasingly, there has been more discussion in relation to infant mental health (IMH) which is concerned with the infant's ability to experience and regulate emotions, develop relationships and their capacity to explore their surroundings (zero to three, 2001). Sensitive and responsive parenting is suggested as being one of the most important factors on an infant's development (Fonagy et al., 2016). Good IMH relies on a positive parent-infant relationship (Zeanah, 2018). Therefore, optimal maternal emotional wellbeing during and after pregnancy is essential (Hanley, 2013).

As well as the relationship between mother and infant, wider family relationships may also become strained (Gavin et al., 2005). Difficulties with maternal mental health are also suggested to be the main cause of maternal mortality in both the UK and Australia (Hayes, 2010). From a financial perspective, there are significant costs to society, with a report completed in 2014 estimating the costs to be £8.1 billion in the UK (Bauer et al., 2014).

Assessment and interventions

Ensuring that symptoms of PMHPs are identified early on is crucial (Hanley, 2013). Paediatric health care staff are well placed to offer universal assessments of depression during the perinatal period, due to their increased contact at this time (Field, 2010). Whilst midwives may be the key professionals during pregnancy (Department of Health (DoH), 2020), health visitors are in optimal positions postnatally (Stefanopoulou et al., 2011).

Health visitors are qualified nurses or midwives who have undertaken further training over a year full time or over two years part time. They work with children from birth to the age of five and their families and aim to deliver services to meet key priorities in relation to maternal mental health, breastfeeding and the health and development of the infant (Rance et al., 2016). Health visiting services are informed by a range of government policy including the Healthy Child Programme (HCP) which sets out guidance for health visiting and school nursing services (Nicholson & Greenwood, 2018). Furthermore, key policies such as 'The 1001 critical days' have played a significant role in shaping how services are delivered (Leadsom et al., 2013).

Guidance from the National Institute for Health and Clinical Excellence (NICE), (2014) recommends that professionals including health visitors ask questions pertaining to depression and anxiety and can use measures such as the Edinburgh Postnatal Depression Scale (EPDS). The EPDS is a 10 item self-report measure used to identify PND (Cox et al., 1987) and has been found to be valid and reliable for its application in different countries and use in other languages (Henshaw et al., 2005). Scores above 10 suggest mild depression, whilst scores above 13 indicate moderate to severe depression (Cox & Holden, 2003). NICE (2014) also highlights the importance of professionals asking about current and past SMI as well as family history of SMI.

Appropriate interventions for PMHPs are needed that can be accessed by women, without having to wait significant periods of time (Misri & Kendrick, 2007). NICE (2014) recommend that women are offered treatment within the first month following assessment and may be offered cognitive behaviour therapy (CBT) for anxiety and depression as well as family and couples therapy for women presenting with SMI (NICE, 2014). Research highlights that interventions including psychosocial aspects, can reduce emotional difficulties related to the perinatal period (McBride & Kwee, 2016).

Barriers in addressing PMHPs

Research literature suggests that PMHPs may be missed by practitioners (Higgins et al., 2018) and therefore left untreated (Priest et al., 2008). A number of barriers exist in relation to the identification of PMHPs as well as them being addressed, including women not feeling able to disclose concerns to practitioners (Fonseca et al., 2015). Furthermore, women report a lack of clarity about the information that is provided, lack of support in making referrals and fear and stigma about disclosing difficulties (Millet et al., 2018). Whilst much of the research has focused on barriers from the women's perspective, a recent review exploring provider and system level barriers cited numerous factors. These included a lack of training for professionals, time constraints and a lack of supervision and support (Bayrampour et al., 2018). These factors may seek to explain why professionals struggle to recognise symptoms and are left feeling unskilled in identifying symptoms (Priest, 2008). Additionally, midwives and health visitors have been found to lack knowledge of the provisions available to women experiencing PMHPs (Stanley et al., 2006).

What is already known?

A number of policies exist regarding the role of the health visitor in supporting the psychological wellbeing of mothers and babies. The Health Visitor Implementation Plan (DoH, 2010) aimed at increasing aspects of the health visitor's role with regards to families. Within this plan, it was suggested that health visitors would take the lead on The Healthy Child Programme (Shribman & Bellingham, 2009) and offer focussed work early on with families, which would begin during pregnancy. The plan advocated for health visitors to utilise the Solihull Approach in their work with families, which is based on the idea of containment, reciprocity and managing behaviour. This approach aids the health visitor to contain parents' feelings, so that parents are better able to contain their infants (Douglas & Ginty, 2001).

A recent review exploring midwives’ experiences of supporting women with PMHPs highlighted two key themes in relation to personal and professional engagement. The review concluded that in order to enhance skill, as well as support changes in attitudes, midwives need support and opportunities to develop their practice (Noonan, Doody, et al., 2017). Similarly, a qualitative meta synthesis focussing on public health nurses (PHNs) (an alternative term used for health visitors) perceptions and experiences of identifying and managing women with PMHPs, found a number of barriers and facilitators in supporting women (Nonnan, Galvin, et al., 2017). These included time constraints and a lack of appropriate referral pathways. The authors suggested that adequate training for PHNs, as well as having access to support groups for women was needed.

Whilst the above review identified important findings, key questions remained. Firstly, whilst listening visits were highlighted as an intervention offered to women, no detail was given in relation to any other interventions that PHNs can offer. Furthermore, as the review was limited to qualitative papers, no insight into the effectiveness of listening visits was offered. Secondly, although it was identified that PHNs need appropriate referral pathways, the review lacked any understanding into the referral practices of PHNs themselves. In addition, the review lacked details pertaining to other ways in which PHNs can support women outside of prescribed interventions. Finally, the review lacked any exploration into the views of PHNs themselves in relation to how they see their role in supporting women. The review will therefore address the aforementioned areas.

By including both quantitative and qualitative research, the following review offers a more comprehensive review of the literature. Quantitative papers include data pertaining to whether interventions delivered by health visitors were effective for women in reducing PMHPs. Qualitative papers aimed to understand the experiences of health visitors in relation to what they offer.

With the above in mind, this review aims to address the following questions:

1) Explore what interventions are offered by health visitors to women experiencing PMPHs
2) Critically assess how effective these interventions are
3) Explore the wider role of the health visitor in supporting women and how they see their role

Whilst it was acknowledged that fathers may also experience difficulties with their mental health during the perinatal period, this was not covered in the review. Findings pertaining to the mother’s perspective were also not included.

Method

Literature search strategy

A preliminary search was undertaken using google scholar. Numerous terms for ‘health visitor’ were used to reflect the differences in terminology across countries. Search terms included (health visitor*) OR (public health nurse*) OR (child and family health nurse) AND (postpartum*) OR (perinatal*) OR (postnatal*) OR (depression) OR (anxiety). Six data bases (CINAHL, EBM reviews, Ovid Medline, Psych info, Taylor & Francis and Wiley) were searched for peer reviewed articles in English between October and December 2019. No date limit was set in order that no relevant data would be missed. The truncation symbol (*) was utilised to ensure papers were not missed as a result of various terms. When screening articles, the following questions were held in mind:

- Did the paper report on an intervention completed by health visitors to manage symptoms or support women with PMHPs?
- Did the paper report on health visitors experience of supporting or managing PMHPs?

Study selection

Initial results from the database search produced 175 papers. Papers were exported to RefWorks in order for duplicate records to be found (of which there were 52). Papers were screened through a process of screening titles, abstracts and then full texts using the inclusion and exclusion criteria (See table 1). Reference lists of retrieved articles were also scanned by hand in order to ensure that articles were not missed and an additional 17 records were found. Figure 1 shows the process of the systematic literature search following the PRISMA guidelines (Moher et al., 2009).

Inclusion / exclusion criteria

Table 1.

Inclusion and exclusion criteria

Inclusion criteria	**Exclusion criteria**
• Available in English • Published in a peer reviewed journal • Papers reporting on health visitors' experiences of supporting/managing women with PMHPs • Quantitative papers where it was clear that health visitors took part in the intervention aimed at supporting women with PMHPs • Papers where health visitors and other professionals were interviewed were included if the views of health visitors were reported clearly	• Not available in English • Non peer reviewed journals, book reviews, opinion articles, unpublished theses • Papers reporting only on the assessment and identification of PMHPs • Papers reporting on mothers' experiences of interventions • Papers reporting on home visits generally not in relation to PMHP's • Quantitative papers which reported on psychological interventions that were carried out by a range of professionals (including health visitors) were excluded as it was unclear whether it was a health

	visitor or another professional carrying out the intervention • Papers reporting on ‘home visitors’ as it was unclear what their professional background was • Qualitative papers where focus group interviews were carried out with nursing professionals other than health visitors • Papers that reported on other nursing professionals carrying out interventions

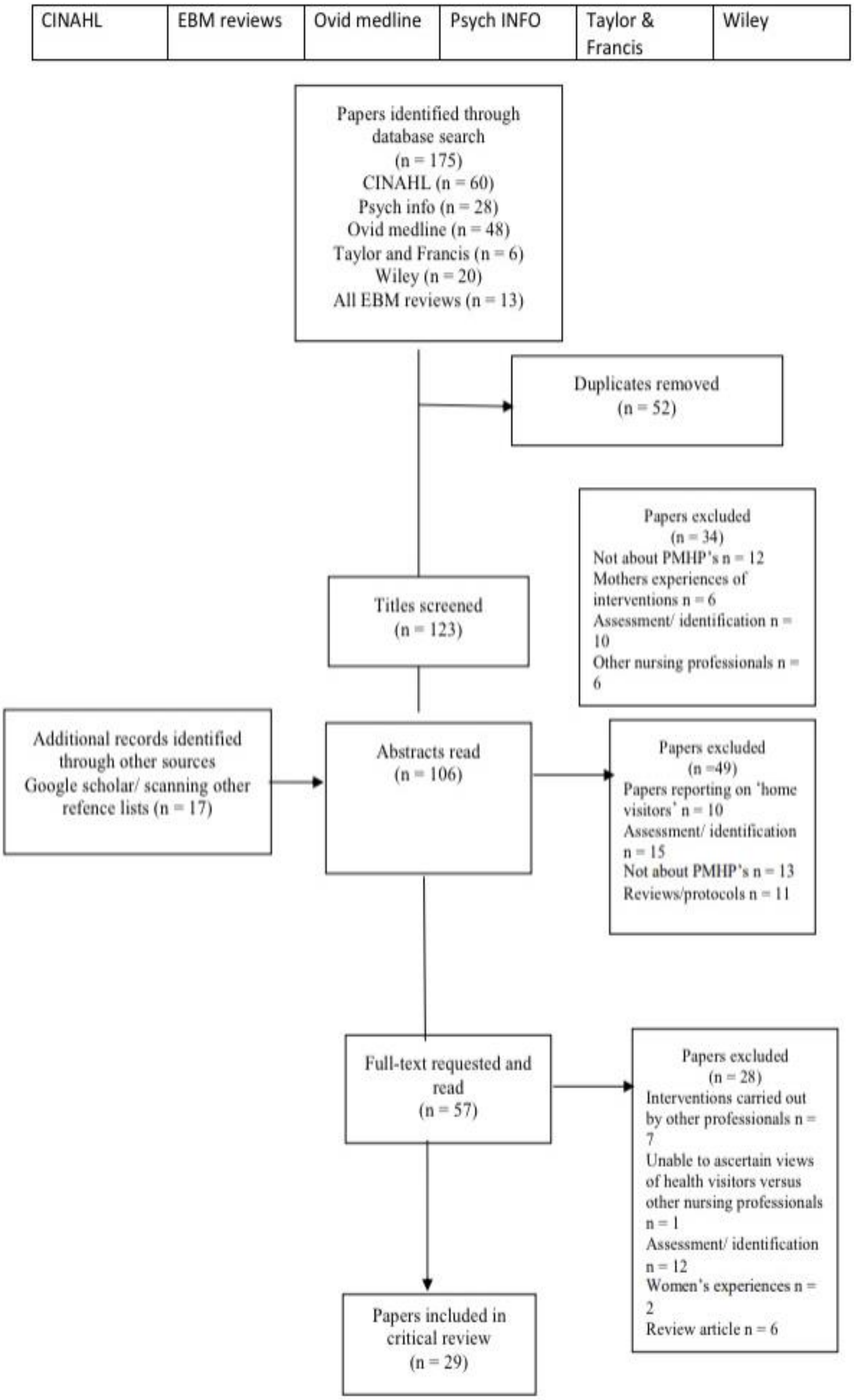

Figure 1. PRISMA flow diagram of study selection and exclusion

Quality appraisal of papers

Quality appraisal checklists were used in order to critically analyse the papers, this enabled a balanced perspective in relation to the paper's findings. Qualitative papers were assessed using the Critical Appraisal Skills Programme (CASP) (CASP, 2018) for qualitative research (appendix A). As there was a mixture of quantitative designs, the Appraisal tool for cross sectional studies (AXIS) was used (Downes et al., 2016) (appendix B) along with the CASP for Randomised Controlled Trials (RCT) (CASP, 2018) (appendix C). Quality checklists were used as way of reflecting on findings of the studies and the conclusions that were drawn. The tools were not used by way of excluding studies and were not rated in terms of numerical value.

Review

Overview of studies and structure

For a summary of papers see appendix D. The search yielded a total of 29 papers that were published between 1989 and 2019 from Australia (n = 3), Canada (n = 1), Cyprus (n = 1) Finland (n = 1), Greece (n = 1), Israel (n = 1), Norway (n = 1), Sweden (n = 1), Republic of Ireland (n = 1) and UK (n = 18). Five employed mixed methods designs, 14 employed qualitative designs (1 of these employed a qualitative ethnographic design) and a further ten employed quantitative methods. A total of 10 papers were included from Noonan, Galvin, et al. (2017) review.

In order to synthesise the data, papers were categorised initially by the methodology they used. Following this, papers were further grouped according to their mains aims and findings in order to answer the aims of this review. It is important to highlight that there was an overlap of findings between papers as well as a lack of agreement in relation to certain terms, for example some papers referred to listening visits as supportive counselling.

Using the relevant findings from papers, the review considered what interventions are offered by health visitors, as well as findings pertaining to the effectiveness of these interventions. The review also focused on other ways that health visitors support women, as well as health visitors' perspectives on how they see their role in supporting women. Finally, the review considered how the health visitor role may develop. Methodological considerations of the papers are outlined in relation to strengths and weaknesses (appendix E).

What interventions do health visitors use to support women?

Listening visits

Qualitatively, seven papers referenced the use of listening visits as a way of supporting women experiencing PMHPs. Health visitors described listening visits as being an early intervention, to support women and give them a space to talk about how they were feeling. They were also seen as useful in reviewing women's symptoms as well as how the family were managing. Whilst listening visits were seen as a short-term intervention, it was recognised that some women may need more visits (Cummings & Whittaker, 2016).

As well as allowing a space for open conversations, some health visitors described them being based on items from the EPDS (Brown & Bacigalupo, 2006) and were reported to cover a range of topics, from housing to relationships (Clark, 2000). During listening visits, health visitors used a range of skills which included motivational and promotional interviewing, as well as using cognitive and behavioural ideas. This provided health visitors with a 'toolbox' when working with women (Morgan, 2017).

Who is offered listening visits?

When deciding who should be offered listening visits, health visitors reported that factors such as the severity of the mental health difficulty, existing social support around women and their personal resources for coping were considered (Cummings & Whittaker, 2016). Listening visits were offered once PND had been identified (Almond & Lathlean, 2011) and when women or their partners asked for them (Alexandrou et al., 2018). Finally, listening visits were offered when higher scores were obtained on the EPDS (a score of 12 or more) (Clark, 2000). In relation to the number of visits offered to women, health visitors advised that whilst they were supposed to offer six visits, they could end up supporting women for a number of years (Jomeen et al., 2013). Moreover, listening visits continued to be offered if they were seen as being of benefit to women (Morgan, 2017).

It is important to reflect on the strengths and limitations of the above papers. Four of the papers reported clear study procedures; however, a number lacked detail in relation to how participants were recruited and chosen for interview (Alexandrou et al., 2018; Jomeen et al., 2013). Demographic information was limited across the papers with two papers reporting no information at all (Jomeen et al., 2013; Morgan, 2017). Just over half included data on the number of years that health visitors had been qualified (Alexandrou et al, 2018; Almond & Lathlean, 2011; Brown & Bacigaulupo 2006; Cummings & Whitaker, 2016) and only one paper reported on the ethnicity of health visitors (Almond & Lathlean, 2011). Of these papers, only three commented on the relationship between the researcher and participant (Brown & Bacigalupo, 2006; Clark, 2000; Morgan, 2017) and only one commented on the process of bracketing (Morgan, 2017).

How effective are listening visits for depression?

Quantitatively, six papers reported on the impact of training health visitors to deliver non-directive/ supportive counselling (also referred to as listening visits) on depression scores (one paper reported on the impact of training health visitors to deliver sessions which were informed with non-directive counselling or cognitive behavioural ideas). Of these six papers, two used pre-test/ post-test designs (Elliott et al., 2001; Glasser et al., 2015) and four used a range of controlled designs (Glavin et al., 2010; Holden et al., 1989; Morrell et al., 2009;

Sharp et al., 2010). Inclusion criteria in relation to EPDS scores ranged from scores of 10 or more (Glasser et al., 2015; Glavin et al., 2010), 11 or more (Sharp et al., 2010) and 12 or more (Elliott et al., 2001; Holden et al., 1989; Morrell et al., 2009).

All papers outlined what the training for health visitors incorporated, which included using active listening. Health visitors were offered varied training across the studies, ranging from 6 hours (Holden et al., 1989; Glasser et al., 2015), 2 days (Sharp et al., 2010) and 5 days (Elliot et al., 2001; Glavin et al., 2010). Interventions were carried out in women's homes (Holden et al., 1989; Morrell et al., 2009; Elliott et al., 2001), clinics (Glasser et al., 2015; Glavin et al., 2010) or a research centre (Sharp et al., 2010).

Women were offered between four sessions (Elliott et al., 2001) and eight sessions (Morrell et al., 2009; Holden et al., 1989; Sharp et al., 2010). Glavin et al. (2010) reported that women were offered between one and seven sessions and Glasser et al. (2015) did not stipulate the number of visits offered. It is important to note these various differences across studies (as to how the intervention was carried out) as they may have had an impact on findings.

Of the two papers employing pre-test post-test designs, both found a reduction in levels of depression as measured using the EPDS. Elliot et al. (2001) found this reduction to be significant, but not for women showing unusually high symptoms (over 19). It is important to note that whilst clients with higher EPDS scores were offered up to four listening visits, they may have not taken this up. As such, changes for some women would have been as a result of factors other than the listening visits.

Glasser et al. (2015) found that at follow up, all but one of the participants who had completed the intervention had scores lower than 10 on the EPDS, this however was not statistically significant. However, there was a significant difference for those participants scoring more than 10 on the EPDS prior to the intervention. It is important to note that out of the 40 women who were offered the intervention, 21 scored 0 on the EPDS which suggested no depression symptomology; however, they were still offered the intervention based on the nurse's judgement. This finding may highlight the nurses over interpretation (in relation to their own judgement) of normal post birth symptoms as signs of depression. Alternatively, this finding may suggest that women were under reporting symptoms, which may call into question the use of the EPDS as a way of measuring depression symptoms. A limitation for both of these studies was the lack of a control group. It is therefore possible that changes may have been influenced by factors other than the intervention offered.

Two of the trials compared non-directive counselling with a control group and found a reduction in depression scores as measured by the EPDS. The trial with the smallest number of participants (n = 50) found a statistically significant reduction in scores between the first and second interview for the women who received the intervention; however, this was not the case for the control group (Holden et al., 1989). The study, as mentioned however, suffered from a relatively small sample. Thus, limiting generalisability, as well as limiting the reliability of the results. Significant reductions on the EPDS for women in the experimental group were also found in Glavin et al. (2009) trial, who employed a larger sample size (experimental and comparison group n = 228). Scores on the EPDS reduced by 5.9 points in the experimental group, compared to 3.4 points in the comparison group. Participants in this study however were not randomised which would have strengthened the results. It is also important to highlight that within the experimental group, 56 participants received between 1 and 7 sessions, the remaining participants received only one session. This however was accounted for in the analyses and did not alter the results.

Morrell et al. (2009) and Sharp et al. (2010) differed to the other two trials. Morrell et al. (2009) randomised women either to receive non-directive counselling, sessions based on cognitive behavioural ideas, or a control group in which women received usual care. Sharp et al. (2010) randomised women to receive either non-directive counselling or antidepressant medication. Morrell et al. (2009) found a reduction in scores for women receiving the intervention; however, no differences were found between the two approaches. Whilst this trial reported on the largest number of pre and post data (n = 418), it suffered from high rates of attrition.

Sharp et al. (2010) found antidepressant medication to be more effective for women at 4 weeks follow up, however, at 18 weeks there was no clear benefit of medication over listening visits. Similarly, to Morrell et al. (2009), this study suffered high rates of attrition and therefore reduced power as the sample size intended was not achieved. Furthermore, women in this study were able to receive the alternative treatment at 4 weeks if their symptoms had not responded. As such, a number of women would have received both treatments. It is therefore possible that a reduction in scores, was down to a combination of both counselling and medication.

A limitation of the above trials was the lack of blinding. Only Holden et al. (1989) was able to blind parts of the trial (psychiatrists carrying out interviews and administering EPDS were not aware of which group the women had been allocated and health visitors were not aware of women in the control group). Blinding is important in minimising bias, as well as maximising validity and would have therefore strengthened the findings. Finally, three of the trials were classed as pragmatic trials (Glavin et al., 2015; Morrell et al., 2009; Sharp et al., 2010). Pragmatic trials differ from ‘explanatory’ trials as they evaluate the effectiveness of everyday practice (Dal-Ré et al., 2018). Whilst external validity may be higher for these trials, causality cannot be inferred and therefore findings have to be interpreted with caution.

Interventions incorporating Cognitive Behavioural Therapy (CBT)

Individual

Qualitatively, one paper reported on the experiences of health visitors offering CBT to treat PND. Health visitors appeared to be familiar with the CBT model and whilst happy to utilise a CBT approach (within a limited time frame of six to eight visits), they did not want to be referred to as counsellors, preferring the term listener. Although health visitors were open to offering this type of intervention, there were concerns with regards to current workloads as well as other areas that may take precedence, for example when there were child protection concerns (Brown & Reynolds, 2014). The authors concluded however, that as health visitors were recruited from one trust, findings could not be generalised.

Quantitatively, Prendergast & Austin (2001) carried out a randomised controlled trial (RCT), comparing a modified version of CBT with standard care (which included offering nonspecific emotional support). Women with a score of 12 or higher on the EPDS, were randomised either to receive CBT or standard care. At 6 weeks follow up, there was a significant improvement in both groups and no significant differences between the intervention and control group. There was however a trend at 6 months of CBT being more effective and women in the CBT group attended all six sessions, versus less than half of women assigned to the control group. Limitations of this RCT include the relatively small sample size (n = 37), which means findings should be interpreted with caution. A strength of this study however was the review of taped sessions in order to establish fidelity to the CBT model.

Group

Quantitatively, two papers reported on groups either incorporating or based on CBT. Van Lieshout et al. (2019) reported on a 9-week CBT group intervention for women scoring 10 or more on the EPDS and found a statistically significant reduction in scores on the EPDS, as well as a reduction in the number of visits to professionals by women (including psychologists and social workers). There were also reductions on the Penn State Worry Questionnaire (PSWP) (Meyer et al., 1990); however, this difference was not statistically significant.

Honey et al. (2002) allocated women with scores above 12 or more on the EPDS to either an 8-week psycho educational group (PEG) which included CBT techniques, or routine primary care (RPC). They found that those allocated to the PEG had significantly reduced scores as measured by the EPDS which was maintained at a 6 month follow up. Both papers suffered from relatively small sample sizes (n = 7 Van Lieshout et al., 2019; n = 45 Honey et al., 2002) which limits the generalisability and reliability of findings. A strength of Honey et al., (2002) however, was the use of an RCT design. In relation to ensuring fidelity to the CBT model, only Van Lieshout et al. (2019) referenced measures for this.

Cognitive behavioural counselling (CBC)

Quantitatively, one paper examined the impact of training health visitors in CBC (similar to CBT but offered in 30 minutes for 6 sessions). Health visitors’ case files were scrutinised for a number of outcomes, including interventions offered to women. Prior to training, only 11% of the cases stated that women had received a range of interventions (and none had received CBC). Following the intervention, this increased to 21% which included offering CBC (Appleby et al., 2003). Whilst this study showed an increase in the number of interventions health visitors offered to women, the study did not assess whether these interventions were effective or not in reducing PND. Furthermore, there was no discussion in relation to ethical approvals or consent.

The wider role of the health visitor in supporting women

Making referrals

Quantitatively, two papers reported on data pertaining to making referrals. Appleby et al. (2003) examined health visitors' clinical practice (by looking through their case files) and attitudes (using self-report measures) in working with women experiencing PND. Referral rates were examined pre and post training. Whilst there was an increase in referral rates in health visitors case files following training (increasing from 5% to 9%), they remained low. Findings highlighted that health visitors were most likely to refer on to the GP pre and post training. In this study, 60% of health visitors pre training and 73% post training thought that they should be the first to work with women experiencing PND, which may explain the low referral rates. Not referring on may therefore be in line with their belief that they should be the ones to work with women initially. This study employed a before and after design and an RCT would have strengthened the findings.

Higgins et al. (2017) however found that 64% of health visitors reported referring on to other services. Participants were also asked to rate their skill level from 1 (not at all skilled) to 5 (very skilled) in relation to discussing referral practices with women. Participants reported the highest skill in talking about making referrals to GPs (M = 4.21, SD = 0.88) and the least skill in talking about making referrals to perinatal mental health (PMH) services (M = 3.49, SD = 1.11) and mental health services (M = 3.08, SD = 1.05). It is however important to highlight, that data in this study was collected through the use of self-report measures, which could be subject to under or over reporting bias.

Twelve papers reported qualitative data in relation to referral practices, with health visitors referring or liaising mostly with the GP (Almond & Lathlean, 2011; Ashford et al., 2017; McConnell et al., 2005; Rush, 2012; Tammentie et al., 2013). Health visitors referenced making referrals for mild PMHPs such as depression, as well as referrals for more specialist services if the PMHP was more severe (Agapidaki et al., 2014; Rush, 2012). Health visitors could also refer to psychiatric services, PMH services (Ashford et al., 2017), mother and baby units (Rush, 2012), psychologists (Borglin et al., 2015; Tammentie et al., 2013) or counselling (Badlwin & Griffiths, 2009). Additionally, health visitors referred women for

CBT (Ashord et al., 2017; Rush, 2012) and to specialist PMH intervention services (Rollans et al., 2013).

Health visitors described relying on their own observations and conversations with women when making decisions about making referrals (Alexandrou et al., 2018), noting a lack of protocol around this (Alexandrou et al., 2018; Brown & Bacigalupo, 2006). Some health visitors were unsure of what services were available (Agapidaki et al., 2014), as well as reporting a lack of services (Jomeen et al., 2013) and a sense that service provisions were determined by the area of the country in which they lived (Ashford et al., 2017). Reasons for not referring on were also linked to thoughts that women may feel judged (Agapidaki et al., 2014).

Reflecting on the strengths and limitations of the qualitative papers reporting on referrals, over half justified the reason for using their chosen design; however five papers lacked any discussion for using their chosen methodology (Alexandrou et al., 2018; Almond & Lathlean, 2011; Ashford et al., 2017; Borglin et al., 2015; Rollans et al., 2013). Whilst the chosen design felt appropriate for the studies' aims, it would have been helpful for this to have been discussed by the authors. A particular strength of one of the studies was that transcripts with themes were sent back to participants for their comment and review (Rush, 2012).

Nonspecific support

Qualitatively, four papers made reference to other ways of supporting women. Health visitors reported offering phone calls and a range of groups to support women (Rush, 2012), as well as 'building communication channels' (Alexandrou et al., 2018). Providing information, offering positive feedback and modelling how women could interact with their babies (if PND had been identified), was also seen as part of the health visitor's role (Tammentie et al., 2013). One paper made reference to using The Solihull Approach and the importance of containment and education with regards to the infant’s development, to highlight helpful ways of ‘sensitive parenting’ (Cummings & Whittaker, 2016).

Limitations of these studies included the lack of discussion of the relationship between the researcher and participants, which is an important component when completing qualitative research. Whilst all the four papers made reference to ethical approvals, only two referenced explicitly gaining informed consent (Alexandrou et al., 2018; Cummings & Whitaker, 2016).

Quantitatively, one paper reported on a number of skills that health visitors felt were part of their role. These included identifying women’s protective and coping strategies (78%), offering family members information about PMHPs (59%) and developing plans with women who already had pre-existing PMHPs (54%) (Higgins et al., 2017). As this was a survey design, it is not possible to tell whether the sample in this study is representative of the target population, thus limiting the generalisability of findings. Moreover, it is possible that health visitors with more of an interest in PMHP were attracted to taking part, leading to response bias.

Do health visitors see supporting women as part of their role?

Qualitatively, seven papers made reference to how health visitors view their role in supporting women with PMHPs. Whilst some health visitors saw their role as offering support (Ashford et al., 2017) others did not (Alexandrou et al., 2018). Some health visitors reported that they were often unable to offer any more support, suggesting that PND was low on the agenda. There was also a sense that women may become over reliant, if health visitors offered support for many years (Chew-Graham et al., 2008).

Listening visits were seen by some as part of their role, however they acknowledged that workload had an impact on what they could offer (Cummings & Whitaker, 2016). Health visitors did not identify as counsellors and felt that their primary role was to offer support and listen (Jones et al., 2015). Finally, health visitors reported an expectation from others that within their role, they could offer something that they were not able to (Brown & Reynolds, 2014).

With regards to the strengths and limitations of these papers, only half included details relating to interview topics (Alexandrou et al., 2018; Ashford et al., 2017 & Chew Graham et al., 2008). Whilst qualitative studies typically have small sizes, two of the papers had particularly low numbers of participants (n = 3 Cummings & Whitaker, 2016; n = 5, Jones et al., 2015).

What are the training needs of health visitors to support women experiencing PMHPs?

Nine papers referenced qualitative findings in relation to training and education needs. Limited training was viewed as one of the main barriers to support women (Agapidaki et al., 2014) and was linked to a lack of confidence in supporting women (Agapidaki et al., 2014; Brown & Reynolds, 2014; Jomeen et al., 2013). Health visitors reported having to teach themselves (Brown & Bacigalupo, 2006; Rush, 2012) and felt that more training in relation to PMHPs was needed during their training (Ashford et al., 2017). Health visitors reported needing more training in relation to treatments (Alexandrou et al., 2018), CBT (Brown & Reynolds, 2014; Cummings & Whitaker, 2016) as well as specifically in relation to listening visits (Morgan, 2017).

One paper described how some health visitors in their area had received training for more specialist roles. This involved leading support groups, seeing women with PMHPs individually and supporting other health visitors (in more of a consulting role). Training for PMH champions had also been offered by the institute of health visiting (iHV) (Ashord et al., 2017). The value of clinical supervision was also reflected in a number of papers as a way of having space to think about certain cases (McConnell et al., 2005; Morgan, 2017; Rush, 2012). Reflecting on the strengths and limitations of the papers, all eight papers offered details regarding data analysis and all but one of the papers (Cummings & Whitaker, 2016) included the study limitations.

Three papers reported on quantitative data pertaining to training. Cummings & Whittaker (2016) found that 90% of participants had been trained in The Solihull Approach (Douglas & Brennan, 2004) and 80% of had received training in relation to working with PMHPs. Only 30% of health visitors however, thought that their training had provided them with adequate learning in relation to PMHPs. Participants (n = 11) suggested that training in CBT would be helpful in supporting women and also provide a frame around visits. The value of training was also highlighted by Elliott et al. (2001), who found an increase in skills in relation to non-directive counselling following training. Jones et al. (2015) also found an increase in self-reported confidence in managing PMHPs following a brief training package. It is important to note however that these studies relied on the use of self-report measures which are subject to bias.

Summary of methodological limitations

Quality checklists were used to explore the strengths and weaknesses of the papers. The majority of the reviewed papers offered clear aims and descriptions of methods and analyses. Most of the papers employed purposive sampling, which is subject to sampling bias and error. The reporting of ethnicity across the reviewed papers was poor and where it was reported, the majority of participants were white British. This is important to acknowledge when considering the generalisability of the findings.

A total of 18 papers (including those using mixed methods) reported on qualitative data. Qualitative research is subject to bias and lower numbers of participants, which limits generalisability (sample sizes of the reviewed papers ranged from 3 to 83 participants). In relation to quality assurance issues, two thirds of papers reported procedures for establishing credibility of the data, for example ensuring inter coder agreement. In relation to researcher reflexivity, the majority of papers did not comment on their motivations for the research, which is an important consideration when completing qualitative research. Additionally, only one paper described a process of reflection and bracketing by keeping a research diary. Only half of the papers justified the reason for using a qualitative approach and less than half provided examples of interview topics/guides. Information pertaining to demographic information was generally lacking, which limits our understanding of the representativeness of participants included in the research. Finally, the majority of qualitative papers did not comment on response bias as to who agreed to take part in the study. Whilst the qualitative data provided a more in-depth exploration of the experiences of participants, findings should be considered in relation to the limitations outlined.

A total of 13 papers (including those using mixed methods) reported on quantitative data, which included controlled trials, pre-test post-test designs and survey designs. Controlled trials offered more robust findings and all but one randomised its participants to conditions, which strengthened findings. Participants were generally well matched between groups and where there were differences, these were accounted for in the analyses in all but one paper (Honey et al., 2002). Quantitative papers generally reported more demographic information as well as collecting data for non-responders. Whilst sample sizes tended to be bigger (sample sizes ranged from 7 to 418 participants), a number were deemed to be relatively small and therefore findings need to be interpreted with caution. Furthermore, only three papers reported sample size calculations.

Discussion

This review summarised and critiqued the literature, in order to understand the role of health visitors in supporting women experiencing PMHPs. The search yielded a total of 29 papers which constituted of qualitative, quantitative and mixed methods designs. It is of interest to note that the majority of the research was carried out in the UK. As well as health visiting practices potentially varying between countries, it is also important to highlight that the UK offers a universal service offered by the NHS which is publicly funded (unlike for example the United States of America). Therefore, findings need to be considered in the context of a universally provided government funded provision which has a particular focus on the Healthy Child Programme and infant mental health.

Qualitative data focused primarily on health visitors' experiences of supporting women experiencing PMHPs. Quantitative data included an examination of whether interventions delivered by health visitors (nondirective counselling and interventions incorporating CBT) would be effective in reducing symptoms of depression. Whilst the review offered some helpful findings, it should be noted that the current body of literature is at an early stage. In relation to particular constructs such as listening visits for example, full agreement did not exist as to exactly what they constituted and when they were offered.

Most papers (n = 21) focussed primarily on depression in the perinatal period. Whilst a number of papers included secondary measures pertaining to anxiety, only one specifically looked at postpartum anxiety and another included both PND and anxiety. Findings highlighted the lack of research in relation to other PMHP's such as OCD and postpartum psychosis and are therefore not representative of the wider spectrum of PHMP's. The focus on depression is reflected in previous research and Alderdice et al. (2013) concluded that most of the research in the area of PMHPs is on depression, with much less of a focus on other difficulties such as stress and anxiety for example.

The review highlighted that health visitors may offer listening visits/ non-directive counselling, in order to support women when difficulties have been identified. They were described as a brief early intervention where women could be offered a space to talk about difficulties. Whilst findings from this review suggest that listening visits were effective in reducing symptoms of PND, research from the woman's perspective has suggested that whilst being helpful, they may not be enough to resolve PND (Turner et al., 2010). The research also highlighted that women with previous experiences of depression found listening visits less helpful.

Increasingly, it appears that health visitors are offering interventions which include cognitive behavioural elements. This review however found a mixed picture, with some evidence suggesting no differences between CBT interventions and non-directive counselling (Morrell et al., 2009; Prendergast & Austin, 2001). This is resonant with existing literature, which suggests that change occurs as a result of factors such as the therapeutic relationship and other nonspecific factors (Martin et al., 2000). As such, it is possible that a range of factors (such as women being able to have a continuous relationship with a health visitor) contributed to changes.

As well as offering interventions, health visitors supported women by making referrals to services and most commonly referred to GPs. The review however highlighted low referral rates from health visitors, which is in line with previous research (Milgrom et al., 2011). Providing support to women, through offering more visits and providing information was also seen as part of the health visitor role. There was a minority of health visitors however who did not see providing support to women with difficulties such as PND as part of their role. Time constraints and heavy workloads were noted as barriers to being able to support women. Factors that have previously been reported by midwives as barriers to supporting women with AND and PND (Jones et al., 2012).

In relation to the development of the health visitor's role, training needs were highlighted by many of the qualitative papers. Health visitors felt that as well as their training covering more about PMH, they also needed more targeted training which could include CBT and other treatments to help women. This is reflected in the wider literature, highlighting a move towards other professionals such as nurses now being trained to deliver CBT (Williams & Martinez, 2008).

Implications for clinical practice

Listening visits and interventions incorporating CBT appear to be helpful to women, that if trained in, health visitors can deliver. In relation to listening visits, whilst they may be a helpful intervention for some women, they may not be enough for others. It would therefore be important that women are carefully considered for this intervention. Women with recurrent mental health problems, or more severe depression may need different support. In relation to offering women CBT, it is important to consider that the perinatal period offers a particular transition for women. It is therefore important, that CBT interventions are tailored to the unique needs of women during this period (O’Mahen et al., 2012).

Up to date training and education is vital in order that health visitors feel confident and equipped to support women experiencing PMHPs. As well as wanting more specific training in CBT for example, health visitors should be offered regular updates with regards to PMHPs. As the role of the health visitor continues to evolve (Oldfield & Carr, 2017), it may be helpful to create more specialist roles for health visitors whereby they can offer consultations to other health visitors.

Front line staff in various contexts are now being trained in interventions such as CBT. Turkington et al. (2006) found that CBT interventions delivered by mental health nurses were of benefit for clients who had received a diagnosis of schizophrenia. Moreover, CBT training provided by psychologists was associated with an increase in confidence and reduction in burnout for homeless workers (Maguire et al., 2017). Psychologists may therefore have a role in offering training and supervision to health visitors in relation to PMHPs and IMH.

This review highlighted low referral rates to services, with GPs being the most common referral. Health visitors may need further support during supervision in order to think about cases where referrals may be appropriate. This may alleviate some of the burden in holding cases with little support. Better communication may also be needed between health visiting teams and services offering supporting for women with PMHPs, including referral processes etc.

NHS staff are now faced with heavy workloads and time constraints. Adding additional roles therefore needs careful consideration, in order that health visitors do not experience burn out. Rifkind (1995) highlights the importance of ‘containing the containers’ for professionals working with complexity. A further role for psychology may therefore be pertinent in offering health visitor’s support through reflective spaces. As well as demands on time, supporting women and their families who are experiencing PMHPs can be emotionally demanding and may impact on professional’s own wellbeing. Consultations would be of benefit to health visiting teams and have been found to be helpful in providing a space for health visitors to reflect on their emotional experiences (Lumsden & Sarankin, 2014).

Implications for future research

The majority of qualitative research in this review was focused primarily on depression and a small number included anxiety. More research is therefore needed exploring the broader range of psychological distress experienced by women (Jomeen et al., 2013). Future qualitative research would benefit from exploring health visitors’ experiences of working with women experiencing other difficulties. This may include how they perceive their role when supporting these women, as well as their experiences of offering interventions like listening visits to these women.

In this review, all of the quantitative research reporting on the impact of interventions focused primarily on depression. Future quantitative research is therefore needed, in order to understand what interventions could be offered by health visitors for women presenting with difficulties other than depression, as well as whether these interventions are effective.

Whilst the qualitative papers offered in depth findings of health visitors experiences, future research would benefit from having larger sample sizes and fuller descriptions of demographic information. In addition, it would be important to comment on the process of reflexivity, which could include ways of bracketing their own ideas and assumptions. Finally, some comment on the relationship between the researcher and participants would be helpful.

Whilst this review focussed on PMHPs, research highlights the significant impact PMHPs can have on the parent-infant relationship. Future research into health visitors' experiences of working with parents where difficulties are present in the parent-infant relationship, is therefore warranted.

Conclusion

In conclusion, this review synthesised qualitative and quantitative findings of existing literature from 29 papers. This offered a comprehensive understanding of what role health visitors play in supporting women experiencing PMHPs. Health visitors were found to have a varied and important role, ranging from offering practical support and information to offering more targeted interventions. Health visitors offer listening visits as well as individual and group CBT informed interventions. Whilst there were a number of limitations with the research, interventions were effective in reducing symptoms of depression as measured by the EPDS.

Health visitors in the reviewed papers mainly saw supporting women as part of their role, however heavy workloads and a lack of training were found to impact what could be offered. It is likely that as services continue to be stretched, health visitors will be expected more and more to support women experiencing distress. It is therefore paramount that appropriate training and supervision is offered, in order that health visitors feel confident and equipped to safely carry out their work. Future research capturing the wider spectrum of mental health difficulties that health visitors work with, would be helpful.

References

Agapidaki, E., Souliotis, K., Jackson, S. F., Benetou, V., Christogiorgos, S., Dimitrakaki, C., & Tountas, Y. (2014). Pediatricians' and health visitors' views towards detection and management of maternal depression in the context of a weak primary health care system: A qualitative study. *BMC Psychiatry*, *14(1)*, 108. https://doi.org/10.1186/1471-244X-14-108

Alderdice, F., McNeill, J., & Lynn, F. (2013). A systematic review of systematic reviews of interventions to improve maternal mental health and well-being. *Midwifery*, *29*(4), 389-399. https://doi.org/10.1016/j.midw.2012.05.010

Alexandrou, F., Sakellari, E., Kourakos, M., & Sapountzi-Krepia, D. (2018). Health visitors' perceptions on their role to assess and manage postpartum depression cases in the community. *Health & Social Care in the Community*, *26*(6), 995-1000. https://doi.org/ 10.1111/hsc.12638

Almond, P., & Lathlean, J. (2011). Inequity in provision of and access to health visiting postnatal depression services. *Journal of Advanced Nursing*, *67*(11), 2350-2362. https://doi.org/10.1111/j.1365-2648.2011.05669.x

Appleby, L., Hirst, E., Marshall, S., Keeling, F., Brind, J., Butterworth, T., & Lole, J. (2003). The treatment of postnatal depression by health visitors: Impact of brief training on skills and clinical practice. *Journal of Affective Disorders*, *77*(3), 261-266. https://doi.org/10.1016/S0165-0327(02)00145-3

Ashford, M. T., Ayers, S., & Olander, E. K. (2017). Supporting women with postpartum anxiety: Exploring views and experiences of specialist community public health nurses in the UK. *Health & Social Care in the Community, 25*(3), 1257-1264. https://doi.org/10.1111/hsc.12428

Austin, M. P., Priest, S. R., & Sullivan, E. A. (2008). Antenatal psychosocial assessment for reducing perinatal mental health morbidity. *Cochrane Database of Systematic Reviews, 8*(4). doi: 10.1002/14651858.CD005124.pub2.

Baldwin, S., & Griffiths, P. (2009). Do specialist community public health nurses assess risk factors for depression, suicide, and self-harm among South Asian mothers living in London? *Public Health Nursing, 26*(3), 277-289. https://doi.org/10.1111/j.1525-1446.2009.00780.x

Barkham, M., Margison, F., Leach, C., Lucock, M., Mellor-Clark, J., Evans, C., Benson, L., Connell, J., Audin, K., & McGrath, G. (2001). Service profiling and outcomes benchmarking using the CORE-OM: Toward practice-based evidence in the psychological therapies. *Journal of Consulting and Clinical Psychology, 69*(2), 184. DOI:10.1037//0022-006x.69.2.184

Bauer, A., Parsonage, M., Knapp, M., Lemmi, V., & Adelaja, B. (2014). The costs of perinatal mental health problems. *London School of Economics and Political Science: London*. http://www.centreformentalhealth.org.uk/

Bayrampour, H., Hapsari, A. P., & Pavlovic, J. (2018). Barriers to addressing perinatal mental health issues in midwifery settings. *Midwifery*, *59*, 47-58. https://doi.org/10.1016/j.midw.2017.12.020

Borglin, G., Hentzel, J., & Bohman, D. M. (2015). Public health care nurses' views of mothers' mental health in paediatric healthcare services: A qualitative study. *Primary Health Care Research & Development, 16*(5), 470-480. http://lup.lub.lu.se/record/5143615

Brown, H., & Bacigalupo, R. (2006). Health visitors and postnatal depression: Identification and practice. *Community Practitioner*, *79*(2), 49.

Brown, M., & Reynolds, P. (2014). Delivery of CBT to treat postnatal depression: Health visitors' perceptions. *Community Practitioner*, *87*(10), 26-9

Brugha, T. S., Bebbington, P. E., Jenkins, R., Meltzer, H., Taub, N. A., Janas, M., & Vernon, J. (1999). Cross validation of a general population survey diagnostic interview: A comparison of CIS-R with SCAN ICD-10 diagnostic categories. *Psychological Medicine*, *29*(5), 1029-1042. DOI:10.1017/s0033291799008892

Chew-Graham, C., Chamberlain, E., Turner, K., Folkes, L., Caulfield, L., & Sharp, D. (2008). GPs' and health visitors' views on the diagnosis and management of postnatal depression: A qualitative study. *British Journal of General Practice*, *58*(548), 169-176. DOI: 10.3399/bjgp08X277212

Clark, G. (2000). Discussing emotional health in pregnancy: The Edinburgh Postnatal Depression Scale. *British Journal of Community Nursing*, *5*(2), 91-98. DOI:10.12968/bjcn.2000.5.2.7170

Cox, J., & Holden, J. (2003). *Perinatal mental health: A guide to the Edinburgh Postnatal Depression Scale (EPDS)*. Royal College of Psychiatrists Publications.

Cox, J. L., Holden, J. M., & Sagovsky, R. (1987). Edinburgh postnatal depression scale (EPDS). *British Journal of Psychiatry*, *150*(6), 782-786. DOI:10.1192/bjp.150.6.782

Critical Appraisal Skills Programme (2018). CASP. (Qualitative Checklist). Retrieved from https://casp-uk.net/wp-content/uploads/2018/01/CASP-Qualitative-Checklist-2018.pdf

Critical Appraisal Skills Programme (2018). CASP (Randomised Controlled Trials) Checklist. Retrieved from: https://casp-uk.net/wp-content/uploads/2018/01/CASPRandomised-Controlled-Trial-Checklist.pdf

Cummings, E., & Whittaker, K. (2016). Listening visits by health visitors as an intervention for mild-to-moderate postnatal depression or anxiety. *Journal of Health Visiting*, *4*(5), 264-270. DOI: 10.12968/johv.2016.4.5.264

Dal-Ré, R., Janiaud, P., & Ioannidis, J. P. (2018). Real-world evidence: How pragmatic are randomized controlled trials labelled as pragmatic? *BioMed Central medicine, 16*(1), 49. doi: 10.1186/s12916-018-1038-2.

Dennis, C. L., Falah-Hassani, K., & Shiri, R. (2017). Prevalence of antenatal and postnatal anxiety: Systematic review and meta-analysis. *The British Journal of Psychiatry, 210*(5), 315-323. https://doi.org/10.1192/bjp.bp.116.187179

Department of Health (DH). (2010) Health Visitor Implementation Plan 2011–2015: A Call to Action. London: DH. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/213110/Health-visitor-implementation-plan.pdf

Department of Health (DH). (2020). Midwifery 2020: Delivering expectations. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/216029/dh_119470.pdf

Douglas, H., & Brennan, A. (2004). Containment, reciprocity and behaviour management: Preliminary evaluation of a brief early intervention (the Solihull Approach) for families with infants and young children. *Infant Observation*, *7*(1), 89-107. https://doi.org/10.1080/13698030408401711

Douglas, H., & Ginty, M. (2001). The Solihull Approach: Evaluation of changes in the practice of health visitors. *Community Practitioner, 74(*6*)*, 222-224.

Downes, M. J., Brennan, M. L., Williams, H. C., & Dean, R. S. (2016). Development of a critical appraisal tool to assess the quality of cross-sectional studies (AXIS). *British Medical Journal Open*, *6*(12), e011458. doi: 10.1136/bmjopen-2016-011458

Elliott, S. A., Gerrard, J., Ashton, C., & Cox, J. L. (2001). Training health visitors to reduce levels of depression after childbirth: An evaluation. *Journal of Mental Health, 10*(6), 613-625. https://doi.org/10.1080/09638230120041362

Field, T. (2010). Postpartum depression effects on early interactions, parenting, and safety practices: A review. *Infant Behavior and Development, 33*(1), 1-6. Doi 10.1016/j.infbeh.2009.10.005

Fonagy, P., Sleed, M., & Baradon, T. (2016). Randomized controlled trial of parent–infant psychotherapy for parents with mental health problems and young infants. *Infant Mental Health Journal, 37*(2), 97-114

Fonseca, A., Gorayeb, R., & Canavarro, M. C. (2015). Women′ s help-seeking behaviours for depressive symptoms during the perinatal period: Socio-demographic and clinical correlates and perceived barriers to seeking professional help. *Midwifery, 31*(12), 1177-1185. doi: 10.1016/j.midw.2015.09.002

Gavin, N. I., Gaynes, B. N., Lohr, K. N., Meltzer-Brody, S., Gartlehner, G., & Swinson, T. (2005). Perinatal depression: A systematic review of prevalence and incidence. *Obstetrics & Gynaecology, 106*(5), 1071-1083. DOI: 10.1097/01.AOG.00000183597.31630.db

Glasser, S., Hadad, L., Bina, R., Boyko, V., & Magnezi, R. (2016). Rate, risk factors and assessment of a counselling intervention for antenatal depression by public health nurses in an Israeli ultra-orthodox community. *Journal of Advanced Nursing*, *72*(7), 1602-1615. doi: 10.1111/jan.12938.

Glavin, K., Smith, L., Sørum, R., & Ellefsen, B. (2010). Supportive counselling by public health nurses for women with postpartum depression. *Journal of Advanced Nursing*, *66*(6), 1317-1327. doi: 10.1111/j.1365-2648.2010.05263.x.

Goebert, D., Morland, L., Frattarelli, L., Onoye, J., & Matsu, C. (2007). Mental health during pregnancy: A study comparing Asian, Caucasian and Native Hawaiian women. *Maternal and Child Health Journal*, *11*(3), 249-255. DOI: 10.1007/s10995-006-0165-0

Hanley, J. (2013). *Perinatal mental health: A guide for health professionals and users*. John Wiley & Sons.

Hayes, B. A. (2010). From ‘postnatal depression’ to ‘perinatal anxiety and depression’: Key points of the National Perinatal Depression Plan for nurses and midwives in Australian primary health care settings. *Contemporary Nurse*, *35*(1), 58-67. doi: 10.5172/conu.2010.35.1.058

Henshaw, C., Elliott, S., & Cox, J. (2005). *Screening for perinatal depression*. Jessica Kingsley Publishers.

Higgins, A., Downes, C., Carroll, M., Gill, A., & Monahan, M. (2017). There is more to perinatal mental health care than depression: Public health nurses reported engagement and competence in perinatal mental health care. *Journal of Clinical Nursing*, *27*(3-4), e476-e487. doi: 10.1111/jocn.13986.

Higgins, A., Downes, C., Monahan, M., Gill, A., Lamb, S. A., & Carroll, M. (2018). Barriers to midwives and nurses addressing mental health issues with women during the perinatal period: The Mind Mothers study. *Journal of Clinical Nursing, 27*(9-10), 1872-1883. doi: 10.1111/jocn.14252

Hipwell, A. E., Goossens, F., Melhuish, E., & Kumar, R. (2000). Severe maternal psychopathology and infant-mother attachment. *Development and Psychopathology, 12* (2), 157-175.

Holden, J. M., Sagovsky, R., & Cox, J. L. (1989). Counselling in a general practice setting: Controlled study of health visitor intervention in treatment of postnatal depression. *British Medical Journal*, 298(6668), 223-226. doi: 10.1136/bmj.298.6668.223

Honey, K. L., Bennett, P., & Morgan, M. (2002). A brief psycho-educational group intervention for postnatal depression. *British Journal of Clinical Psychology, 41*(4), 405-409. https://doi.org/10.1348/014466502760387515

Howard, L. M., Molyneaux, E., Dennis, C. L., Rochat, T., Stein, A., & Milgrom, J. (2014). Non-psychotic mental disorders in the perinatal period. *The Lancet*, *384*(9956), 1775-1788. https://doi.org/10.1016/S0140-6736(14)61276-9

Johanson, R., Chapman, G. Murray, D. Johnson, I. & Cox, J. (2000) The North Staffordshire Maternity Hospital prospective study of pregnancy associated depression. *Journal of Psychosomatic Obstetrics and Gynecology, 21*(2), 93–97. DOI: 10.3109/01674820009075614

Jomeen, J., Glover, L., Jones, C., Garg, D., & Marshall, C. (2013). Assessing women's perinatal psychological health: Exploring the experiences of health visitors. *Journal of*

Reproductive and Infant Psychology, *31*(5), 479-489. https://doi.org/10.1080/02646838.2013.835038

Jones, C. J., Creedy, D. K., & Gamble, J. A. (2012). Australian midwives' awareness and management of antenatal and postpartum depression. *Women and Birth*, *25*(1), 23-28. https://doi.org/10.1016/j.wombi.2011.03.001

Jones, C., Jomeen, J., Glover, L., Gardiner, E., Garg, D., & Marshall, C. (2015). Exploring changes in health visitors' knowledge, confidence and decision-making for women with perinatal mental health difficulties following a brief training package. E*uropean Journal for Person Centered Healthcare, 3*(3), 384-391. https://doi.org/10.5750/ejpch.v3i3.1012

Khan, L. (2015). Falling through the gaps: Perinatal mental health and general practice. London: Centre for Mental Health. http://www.rcgp.org.uk/~/~/media/Files/CIRC/Perinatal-Mental-Health/RCGP-Exec-Summary-Falling-through-the-gaps-PMH-and-generalpractice-Mar-2015.ashx

Kurstjens, S. & Wolke, D. (2001) Effects of maternal depression on cognitive development of children over the first 7 years of life. *Journal of Child Psychology and Psychiatry*, *42*(5), 623–636. https://doi.org/10.1111/1469-7610.00758

Leigh, B., & Milgrom, J. (2008). Risk factors for antenatal depression, postnatal depression and parenting stress. *BMC Psychiatry*, *8*(1), 24. https://doi.org/10.1186/1471-244X-8-24

Lejuez, C. W., Hopko, D. R., Acierno, R., Daughters, S. B., & Pagoto, S. L. (2011). Ten-year revision of the brief behavioural activation treatment for depression: Revised treatment manual. *Behavior Modification, 35*(2), 111-161. https://doi.org/10.1177/0145445510390929

Lovejoy, M. C., Graczyk, P. A., O'Hare, E., & Neuman, G. (2000). Maternal depression and parenting behavior: A meta-analytic review. *Clinical Psychology Review*, *20*(5), 561-592. DOI:10.1016/S0272-7358(98)00100-7

Lovibond, S. H., & Lovibond, P. F. (1995). Depression Anxiety Stress Scales. *PsycTESTS Dataset*. doi:10.1037/t01004-000

Lumsden, V., & Sarankin, M. (2014). The process of consultation to a health visiting team based on the Solihull approach: A critical reflection. *Community Practitioner*, *87*(10), 34-37.

Maguire, N., Grellier, B., & Clayton, K. (2017). The impact of CBT training and supervision on burnout, confidence and negative beliefs in a staff group working with homeless people. *Behavioural and Cognitive Psychotherapy*.

Martin, D. J., Garske, J. P., & Davis, M. K. (2000). Relation of the therapeutic alliance with outcome and other variables: A meta-analytic review. *Journal of Consulting and Clinical Psychology*, *68*(3), 438. https://doi.org/10.1037/0022-006X.68.3.438

McBride, H. L., & Kwee, J. L. (2016). Focusing on the mother in maternal health care: A literature review of perinatal mental health needs and favourable interventions. *The Journal of Psychological Therapies in Primary Care*, *5*(1), 1-25.

McConnell, J., Baker, M., & Marks, L. (2005). Experiencing a dilemma-accounts of working with PND. *Community Practitioner*, *78*(7), 251.

Meyer, T. J., Miller, M. L., Metzger, R. L., & Borkovec, T. D. (1990). Development and validation of the penn state worry questionnaire. *Behaviour Research and Therapy*, *28*(6), 487-495. DOI:10.1016/0005-7967(90)90135-6

Milgrom, J., Holt, C. J., Gemmill, A. W., Ericksen, J., Leigh, B., Buist, A., & Schembri, C. (2011). Treating postnatal depressive symptoms in primary care: A randomised controlled trial of GP management, with and without adjunctive counselling. *BMC Psychiatry*, *11*(1), 95. doi: 10.1186/1471-244X-11-95.

Millett, L., Taylor, B. L., Howard, L. M., Bick, D., Stanley, N., & Johnson, S. (2018). Experiences of Improving Access to Psychological Therapy Services for Perinatal Mental Health Difficulties: A Qualitative Study of Women's and Therapists' Views. *Behavioural and Cognitive Psychotherapy*, *46*(4), 421-436. doi: 10.1017/S1352465817000650.

Misri, S., Kendrick, K., (2007). Treatment of perinatal mood and anxiety disorders: A review. *Canadian Journal of Psychiatry*. *52*(8), 489–98. https://doi.org/10.1177/070674370705200803

Misri, S., & Kendrick, K. (2007). Obsessive-compulsive disorder in the perinatal period: A review of the literature. *Current Psychiatry Reviews*, *3*(4), 265-270.

Misri, S., & Kendrick, K. (2008). Perinatal depression, fetal bonding, and mother-child attachment: A review of the literature. *Current Paediatric Reviews*, *4*(2), 66–70. DOI: 10.2174/157339608784462043

Moher, D., Liberati, A., Tetzlaff, J., & Altman, D. G. (2009). Preferred reporting items for systematic reviews and meta-analyses: The PRISMA statement. *Annals of internal medicine*, *151*(4), 264-269.. DOI:10.7326/0003-4819-151-4-200908180-00135

Montgomery, S. A., & Åsberg, M. (1979). A new depression scale designed to be sensitive to change. *The British Journal of Psychiatry*, *134*(4), 382-389. DOI:10.1192/bjp.134.4.382

Morgan, M. (2017). A qualitative study to explore health visitors' perceptions of listening visits. *Journal of Health Visiting*, *5*(10), 506-511.

Morrell, C. J., Slade, P., Warner, R., Paley, G., Dixon, S., Walters, S. J., Brugha, T., Barkham, M., Parry, G, J., & Nicholl, J. (2009). Clinical effectiveness of health visitor training in psychologically informed approaches for depression in postnatal women: Pragmatic cluster randomised trial in primary care. *British Medical Journal, 338,* a3045. doi: 10.1136/bmj.a3045

National Institute for Health and Clinical Excellence (NICE). (2014). Antenatal and Postnatal Mental Health: Clinical Management and Service Guidance. London, UK: NICE. https://www.nice.org.uk/guidance/cg192

Nicholson, W., & Greenwood, P. (2018). Best start in life and beyond: Improving public health outcomes for children, young people and families: Guidance to support the commissioning of the Healthy Child Programme 0-19: Health visiting and school nursing services.

Noonan, M., Doody, O., Jomeen, J., & Galvin, R. (2017). Midwives’ perceptions and experiences of caring for women who experience perinatal mental health problems: An integrative review. *Midwifery, 45,* 56-71. doi: 10.1016/j.midw.2016.12.010.

Noonan, M., Galvin, R., Doody, O., & Jomeen, J. (2017). A qualitative meta-synthesis: Public health nurses’ role in the identification and management of perinatal mental health problems. *Journal of Advanced Nursing*, *73*(3), 545-557. doi: 10.1111/jan.13155.

Oldfield, V., & Carr, H. (2017). Postnatal depression: Student health visitors' perceptions of their role in supporting fathers. *Journal of Health Visiting*, *5*(3), 143-149. https://doi.org/10.12968/johv.2017.5.3.143

O'Mahen, H., Fedock, G., Henshaw, E., Himle, J. A., Forman, J., & Flynn, H. A. (2012). Modifying CBT for perinatal depression: What do women want? A qualitative study. *Cognitive and Behavioural Practice, 19*(2), 359-371. https://doi.org/10.1016/j.cbpra.2011.05.005

O'Hara, M. W., & Wisner, K. L. (2014). Perinatal mental illness: Definition, description and aetiology. *Best Practice & Research Clinical Obstetrics & Gynaecology, 28*(1), 3-12.

Paschetta, E., Berrisford, G., Coccia, F., Whitmore, J., Wood, A. G., Pretlove, S., & Ismail, K. M. (2014). Perinatal psychiatric disorders: An overview. *American Journal of Obstetrics and Gynecology, 210*(6), 501-509. doi: 10.1016/j.ajog.2013.10.009

Prendergast, J., & Austin, M. P. (2001). Early childhood nurse-delivered cognitive behavioural counselling for post-natal depression. *Australasian Psychiatry*, *9*(3), 255-259. https://doi.org/10.1046/j.1440-1665.2001.00330.x

Priest, S. R., Austin, M. P., Barnett, B. B., & Buist, A. (2008). A psychosocial risk assessment model (PRAM) for use with pregnant and postpartum women in primary care settings. *Archives of Women's Mental Health*, *11*(5-6), 307. doi: 10.1007/s00737-008-0028-3

Rance, S. (2016). Specialist Health Visitors in Perinatal & Infant Mental Health: What they do and why they matter. London: Health Education England. Retrieved from https://www.hee.nhs.uk/sites/default/files/documents/Specialist%20Health%20Visitors%20in%20Perinatal%20and%20Mental%20Health%20FINAL%20low%20res.pdf

Rifkind, G. (1995). Containing the containers: The staff consultation group. *Group analysis*, *28*(2), 209-222. https://doi.org/10.1177/0533316495282010

Rollans, M., Schmied, V., Kemp, L., & Meade, T. (2013). Negotiating policy in practice: Child and family health nurses' approach to the process of postnatal psychosocial assessment. *Bio Med Central Health Services Research*, *13*(1), 133. https://doi.org/10.1186/1472-6963-13-133

Rush, P. (2012). The experience of maternal and child health nurses responding to women with postpartum depression. *Maternal and Child Health Journal*, *16*(2), 322-327. doi: 10.1007/s10995-010-0688-2

Sharp, D. J., Chew-Graham, C., Tylee, A., Lewis, G., Howard, L., Anderson, I., Abel, K., Turner, K, M., Hollinghurst, S, P., Tallon, D., McCarthy, A., Peters, T, J. (2010). A pragmatic randomised controlled trial to compare antidepressants with a community-based psychosocial intervention for the treatment of women with postnatal depression: The RESPOND trial. *Health Technology Assessment*, *14*(43), 1-153. doi: 10.3310/hta14430

Shribman, S., & Billingham, K. (2009). *Healthy child programme: Pregnancy and the first five years of life*. Department of Health. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/167998/Health_Child_Programme.pdf

Sit, D., Rothschild, A. J., & Wisner, K. L. (2006). A review of postpartum psychosis. *Journal of Women's Health*, *15*(4), 352-368.

Spielberger, C. D., Gorsuch, R. L., Lushene, R., Vagg, P. R., & Jacobs, G. A. (1983). *Manual for the State-Trait Anxiety Inventory*. Palo Alto, CA: Consulting Psychologists Press.

Stanley, N., Borthwick, R. & Macleod, A. (2006) Antenatal depression: Mothers' awareness and professional responses. *Primary Health Care Research and Development*, *7*(3) 257–268. https://doi.org/10.1191/1463423606pc295oa

Stein, A., Pearson, R. M., Goodman, S. H., Rapa, E., Rahman, A., McCallum, M., Howard, L, M., & Pariante, C. M. (2014). Effects of perinatal mental disorders on the fetus and child. *The Lancet, 384*(9956), 1800-1819. doi: 10.1016/S0140-6736(14)61277-0

Tammentie, T., Paavilainen, E., Åstedt-Kurki, P., & Tarkka, M. T. (2013). Public health nurses in Finland help to prevent postnatal depression. *Primary Health Care, 23*(1). https://doi.org/10.1155/2013/813409

Turkington, D., Kingdon, D., Rathod, S., Hammond, K., Pelton, J., & Mehta, R. (2006). Outcomes of an effectiveness trial of cognitive–behavioural intervention by mental health nurses in schizophrenia. *The British Journal of Psychiatry, 189*(1), 36-40. DOI: 10.1192/bjp.bp.105.010884

Turner, K. M., Chew-Graham, C., Folkes, L., & Sharp, D. (2010). Women's experiences of health visitor delivered listening visits as a treatment for postnatal depression: A qualitative study. *Patient Education and Counselling*, *78*(2), 234-239. doi: 10.1016/j.pec.2009.05.022.

Van Lieshout, R. J., Layton, H., Feller, A., Ferro, M. A., Biscaro, A., & Bieling, P. J. (2019). Public health nurse delivered group cognitive behavioral therapy (CBT) for postpartum depression: A pilot study. *Public Health Nursing*, *37*(1), 50-55. doi: 10.1111/phn.12664

Williams, C., & Martinez, R. (2008). Increasing access to CBT: Stepped care and CBT self-help models in practice. *Behavioural and Cognitive Psychotherapy, 36*(6), 675-683. https://doi.org/10.1017/S1352465808004864

Zeanah, C. H. (Ed.). (2018). *Handbook of infant mental health*. Guilford Publications.

Zero to Three. (2001). *Definition of infant mental health.* Washington, DC: Zero to Three Infant Mental Health Steering Committee.

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MAJOR RESEARCH PROJECT SECTION B:

EMPIRICAL PAPER

How do health visitors make sense of their experience of talking about difficulties with the parent-infant relationship? An Interpretative Phenomenological Analysis

WORD COUNT: 7401 (plus 670 additional words)

A thesis submitted in partial fulfilment of the requirements of Canterbury Christ Church University for the degree of Doctor in Clinical Psychology and prepared for submission in the journal ‘Infant Mental Health’

June 2020

SALOMONS INSTITUTE

CANTERBURY CHRIST CHURCH UNIVERSITY

Abstract

Background: The parent-infant relationship is important for healthy child development and optimal infant mental health. Early identification of any difficulties is key so that support can be provided. Health visitors are in prime positions to highlight any difficulties due to their continued contact with parents and infants. Limited research exists however about health visitors' experiences of talking about difficulties with the parent-infant relationship.

Methods: Semi-structured interviews were held with ten qualified health visitors. Data was analysed using Interpretative Phenomenological Analysis (IPA).

Results: Five master themes emerged from the data; the felt experience- connection to the personal; the impact of containing and carrying the burden; how to name the elephant in the room; coping mechanisms and some things help, some things hinder.

Conclusions: Findings highlighted the emotional burden on participants, as well as a pull to avoid having conversations about the parent-infant relationship. Findings were discussed in relation to the existing literature and limitations were outlined. Implications for clinical practice included the importance of health visitors being offered reflective spaces and consultations, which could be facilitated by parent infant services and psychologists. Future research may focus on health visitors' experiences of working with fathers where there are difficulties with the parent-infant relationship, as health visitors in this study largely spoke about working with mothers.

Keywords: health visitors, parent-infant relationship

Introduction

Considerable evidence now highlights the role that early experiences play in healthy child and adult development (Shonkoff & Phillips, 2000). Early interactions are essential in creating 'pathways' for later life (Shore, 1997) and the parent-infant relationship is suggested to be one of the most important factors in the development of a child's brain (Winston & Chicot, 2016). Good parenting and the development of a secure bond is therefore vital for children to be able to thrive (Moullin et al., 2014), as well as ensuring optimal infant mental health (IMH) (Bowlby, 1997).

Attachment theory posits that children who have had their needs consistently met will come to view their primary caregivers as safe and loving and as a result will form ‘secure attachments’ (Bowlby, 1969). Moreover, it is suggested that the parent’s capacity to regulate the emotional states of their children is fundamental (Slade et al., 2005). Early attachment relationships are therefore seen as significant for children’s development (Fonagy, 2003) and children who have not developed secure attachments to their caregivers are at risk of significant difficulties related to their social, cognitive and emotional development (Ranson & Urichuk, 2008). Insecurely attached children may also struggle with forming positive future relationships (McDonald, 2011), as well as finding it harder to manage stress in later life (Cooper et al., 1998).

For many women, a healthy bond will develop between them and their baby which is deemed to be ‘good enough’, however for some women this will prove more difficult (Appleton et al., 2013). Reasons for difficulties in developing healthy attachments include perinatal mental health problems (PMHPs) such as depression, which may affect the mother’s capacity to sufficiently interact with her infant (Milgrom et al., 2004). Furthermore, for some parents, difficult experiences in their own childhood may make it harder for them to build relationships with their infant (Sutter-Dallay et al., 2003). Psychoanalytic theory suggests that parents' own unresolved conflicts may be re-enacted when they themselves become parents (Lieberman et al., 2006) and offers helpful insights into the inter-generational transmission of complex family dynamics (Fraiberg et al., 1975).

Health visitors (also known as public health nurses) offer community-based services to children and their families and lead on the Healthy Child Programme (HCP) which aims to ensure the wellbeing of infants and children by providing early intervention (Shribman & Billingham, 2009). Health visitors are qualified nurses or midwives who have undergone further specialist training. The DoH (2011) recommends that parenting and attachment is incorporated into the training in order that health visitors are able to offer support if difficulties with the parent infant relationship arise. Once qualified, health visitors can progress from becoming perinatal and infant mental health champions to completing more specialist training to become specialist health visitors in perinatal and infant mental health (Rance et al., 2016). Health visitors may also support women experiencing PMHPs by offering listening visits (Cummings & Whitaker, 2016), as well as offering interventions such as cognitive behavioural therapy (CBT) (Brown & Reynolds, 2014).

Whilst the process of diagnosing attachment disorders may lie with clinical psychologists (Howe, 1999), health visitors can offer helpful insights into the developing relationship. Health visitors use various strategies to gather information including direct parent infant observations (Wilson et al., 2008), as well as relying on their own judgement and intuition (McAtamney, 2011). Although specific tools are available for the assessment of the parent-infant relationship (Lotzin et al., 2015), these are not utilised by health visitors (Appleton et al., 2013) and even when tools are available, they may not be used (Pettit, 2008).

Having conversations about the parent-infant relationship may prove difficult amongst health professionals (Bailey, 2009). Research around clinicians giving ‘bad news’ highlights a range of patient and practitioner factors that make it difficult to have these types of conversations. Patient factors include the perceived impact that the bad news could have. Practitioner factors include not wanting to be the person to cause discomfort in the patient, as well as worries about being blamed by the patient (Buckman, 1984). When conversations are deemed difficult, clinicians are more likely to avoid or postpone having them (Christakis & Iwashyna, 1998). Given that attachments between parents and infants are established by seven or eight months (Iwaniec & Sneddon, 2001), it is important that difficulties are spoken about early on in order that interventions can be offered. As well as health visitors themselves offering interventions such as listening visits and support at home (McAtamney, 2011), they can also inform appropriate referrals to services (Appleton et al., 2013) such as parent-infant relationship (PIP) or under-fives services.

Rationale for research

Due to the lack of research in relation to health visitors’ experiences of talking about difficulties with the parent-infant relationship, this study was felt to be important in addressing a unique gap. This study will hope to understand health visitors lived experience of talking about difficulties with the parent-infant relationship. This research provides an opportunity to understand the facilitators and barriers when having these types of conversations, as well highlighting what support may be needed for health visitors.

Aims of research

To gain an in depth understanding of health visitors’ experiences of talking about difficulties with the parent-infant relationship.

Research questions

a. How do health visitors experience talking about difficulties with the parent-infant relationship?
b. How do health visitors make sense of how they talk with parents about difficulties with the parent-infant relationship?
c. Understand how health visitors make sense of their role in relation to these difficulties

Method

Design

This study carried out semi-structured interviews using Interpretative Phenomenological Analysis (IPA), which is concerned with understanding how people make sense of their experiences (Smith et al., 2009). In IPA, through a process of careful interpretation, the researcher makes sense of the participant making sense of their lived experience (Reid et al., 2005). The idiographic nature of IPA which aims to understand the particular experience of a person in a given context, was felt to be appropriate in an area that is currently under researched. IPA, whilst often used in health psychology, is increasingly being used to study social and clinical psychology (Reid et al., 2005) and has been used in previous research aiming to understand health visitors' roles in various contexts (Giltenane et al., 2015; Oldfield & Carr, 2017).

Participants

At the outset of this process with the recommendation of a homogenous sample for IPA (Pietkiewicz & Smith, 2014), health visitors were intended to be recruited through one NHS trust. Due to difficulties however with recruitment, the recruitment strategy was changed to include three NHS sites as well as recruiting via one non-NHS organisation. It should be noted that health visitors recruited through non-NHS organisation were also NHS employees; however, interviews were conducted in their own time and not on NHS premises.

Ten participants were recruited for the study as is within the suggested sample size when using IPA (Smith & Osborn, 2004). Inclusion criteria to take part in the study was being a qualified health visitor, currently working with parents with children aged between 0-4 years old and being able to speak English at a level to engage in an interview. All participants were women aged 36- 57 years old and had been qualified as a health visitor for between 4 and 19 years (see table 1 for demographic information). Seven out of the ten participants reported having had additional training in IMH or the parent-infant relationship. All health visitors recruited were currently working within NHS contexts. Health visitors worked alongside families from diverse backgrounds including families who were experiencing high socioeconomic deprivation, mental health difficulties and substance misuse.

Table 1. Participant demographic information

Table 1

Participant demographic information

Participants	Age	Ethnicity	Years qualified as HV	Years in current role	Training received on parent/infant relationship or IMH
HV 1	41	White	4.5	4.5	Yes Understanding your baby
HV 2	57	White British	15	15	No
HV 3	56	White British	19	2	Yes Dyadic Assessment of Naturalistic Caregiver-child Experiences
HV 4	37	White British	5	5	Yes IMH
HV 5	56	White British	19	19	Yes Masters in IMH
HV 6	57	White British	13	2	Yes Parent/ infant observation (Anna Freud)

HV 7	36	White British	6	6	No
HV 8	42	White British	9	9	Yes Babies Brains and Bonding, Understanding your baby, Early attachment observation, Stress in infants, Watch, Wait and Wonder
HV 9	41	British/ Indian	14	1	No
HV 10	44	White British	4	4	Yes IMH

Procedure

An advertisement (appendix I) was sent out to three NHS trusts and one non-NHS organisation, which outlined the study and included contact details of the researcher. People who expressed an interest to the researcher via email, were then sent the participant information sheet (appendix J) and consent form (appendix K) and offered the chance to ask any further questions about participating in the study. Participants who were recruited through the NHS advertisement and consented to participation, were invited to take part in a face to face interview. These interviews were held in a private room on the NHS premises where they worked. Those recruited through non-NHS organisations were invited to have a phone interview. Consent forms were either completed in person or emailed to the researcher.

Interviews

IPA uses an inductive (not theory-driven) approach and therefore broad questions and prompts were used to focus the interview (appendix L). This way, the researcher was free to pursue important lines of discussion that were opened up by participants. Each participant was interviewed individually either face to face or via the telephone. Interviews lasted between 53 and 77 minutes. Participants were reminded about the limits of confidentiality and their right to withdraw at any time. Interviews were carried out over a period of four months. Interviews were recorded using a Dictaphone, uploaded to a secure password protected laptop and transferred to an encrypted memory stick. Interviews were transcribed verbatim and any confidential information was anonymised. Transcribed interviews were anonymised and kept on a password protected laptop. Transcripts are stored for ten years.

Data Analysis

In line with the suggested protocol for analysing data when using IPA (Smith et al., 2009), the first stage involved the reading and re-reading of transcripts in order to gain familiarity with the data. The second stage involved making initial notes and highlighting anything that stood out to the researcher. The researcher began the close line by line analysis using the right-hand margin, for explanatory notes or comments which seemed important to the participant and were related to the research question. The left-hand margin was used to note emerging themes, which were transferred to a separate document. A table was created with preliminary themes and quotes in order that the researcher stayed close to the participants experience (appendix Q). Similar themes were grouped together to form clusters, which led to the development of superordinate and sub themes (appendix R).

This process was repeated for each transcript, which led to a shift from exploring what was individual to a participant, to what was shared amongst participants (Cooper et al., 2012). Themes that were similar from each transcript were grouped together to create superordinate and sub themes (appendix S). The process of analysing the data was not linear and involved transcripts being continually reviewed. A table was created to document superordinate and sub themes and related quotes from participants (appendix T).

Quality assurance and reflexivity

Qualitative research has become increasingly popular due to its ability to offer something different to quantitative methodologies (Yardley, 2000). In order to ensure quality of the research, guidelines produced by Yardley (2000) were followed during the research process. In order to ensure ‘sensitivity to the context’, the researcher familiarised herself with existing literature. Furthermore, the researcher had informal conversations with parents about their experiences of health visitors and the types of conversations they have with them. A bracketing interview (appendix M) was held with a trainee clinical psychologist, prior to the researcher carrying out interviews. This allowed the researcher to reflect on some of her own assumptions and biases, which included an assumption that conversations about the parent-infant relationship may not be happening with parents. The interview also allowed the researcher to engage in a process of reflexivity in thinking about her motivations for undertaking this research. The completion of a reflective research diary throughout the process was helpful in noting key emotional responses with regards to recruitment processes, as well as from completing interviews (appendix N). As a novice to IPA, the researcher followed guidance from Smith et al. (2009) which ensured methodological rigor. The process of data collection and analysis was documented. A number of annotated transcripts and a table of developing themes with participants quotes were shared with the lead supervisor. This ensured that emergent themes were grounded in the original data and allowed for inter coder agreement (Yardely, 2008).

Ethical considerations

Ethical approval was gained through the Health Research Authority (HRA) (appendix F) and Salomons Ethics Committee (appendix G). Participants were advised of their right to withdraw from the research at any time without the need to give an explanation, they were also encouraged to contact the researcher if they had any questions following the interview. Although deemed unlikely, the potential for safeguarding issues to arise such as participants disclosing risk information related to themselves or others, was considered.

Results

The analysis resulted in five superordinate themes and fifteen sub themes which are described below. Table 2 provides a description of superordinate and sub themes along with participants quotes.

Table 2. Themes and illustrative quotes

Table 2

Themes and illustrative quotes

Superordinate theme	Sub theme	Participants quotes	People contributing to sub theme
The felt experience-connection to the personal	Powerful feelings evoked	*I mean really it's a sad feeling, I feel sad for them yeah concerned for them, feel sad and concerned (HV 6)*	10
	Maternal self-elicited	*Oh, I mean as a parent myself, I know that it is hard. It's not easy, and I think parenting, there's no book to say how it's done right (HV 8)*	7
	Being the one to judge and being judged (a parallel process)	*Well, because I think they can't understand how I wouldn't criticise, or particularly, "But how can you not judge?"…I think if you went in with a judgemental, then you just wouldn't go back in again. And it's not about my judgement, well, it is, because you're always judging, "Is this child safe? Is this mum safe?" So you are making judgements, but you're not making criticisms* so I *think the judgements that I'm doing are based on (sighs), on things like safety and wellbeing (HV 3)* *Because sometimes people don't know, they think health visitors come in to make sure their house is clean, they come in to snoop around, they come in to ask lots of questions (HV 8)*	8

The impact of containing and carrying the burden	The container – a process of re- parenting the parent	*Because the adult's needs are so powerful, I suppose, and so complicated. And these are abused children, these parents are abused children, so there's no adult or parental part you can connect with. Do you see what I mean? (HV 5)* *But I guess with regards to relationships, it's hard because for some families, and for some mums, they may have never had it their self. So it's about teaching them that this is how you can do it a better way, or support them in changes for their babies, and it don't carry on in the babies like it has done for them (HV 8)*	10
	Hopeless, helpless and powerless	*Yeah so I mean I like to try and sort of say at least I've tried my best but then sometimes feels like banging your head against the wall , I don't know if that's the right expression, it's a bit dramatic err but yeah it can be feel a bit hopeless or helpless may be a better word you feel like you want to help but they don't want the help (HV 1)*	7
	Left to carry it	*But yeah, I wasn't supported, and I felt really deflated, and it came across as I just failed for that child, and that's horrible, a horrible feeling, and I will just carry that with me (HV 7)*	7
How to name the elephant in the room	Reframing	*So for them, and for them to hear it, even if it is challenging, even if you have to say something challenging, you can still say something positive. (HV 8)*	6
	It's not the right time	*That's not something I'm going to say in a ten-minute clinic, because that would have to be framed in a very particular way to get her attention in the right way without putting a barrier up again (HV 4)*	6

	Walking on eggshells	*Because I think you have to find the way to point it out to them without…quite often when people don't have that insight they are much more defensive to work with and are much more you know there quite sensitive to anything that they could interpret as criticism ..so you have to choose your words very carefully (HV 6)*	9
Coping mechanism	Protecting the self	*Because you have to protect yourself, and I think when you become aware of a whole different way of working, I have become aware that you can take on too much of the family…. So I've become more boundaried (HV 5)*	8
	Professionalism- the safety of knowing and having the solution	*I'm looking at both of these children are acting like this do I think we need to get services in for example do we need SALT education psychology, do I think this is something pathological, do I think these children have a behavioural issue, do I think these children have autism which is what she thinks or do I think its environmental do I think it's an attachment issue that's what I've got to look at (HV 2)*	5
	Sharing the burden	*But maybe next visit you can come away, you can get some supervision from your colleagues, and then you might find that you have to do it a different way or say something a different way, or take somebody else with you to try and support you. (HV 8)*	5
Some things help Some things hinder	Relationship both facilitates yet blocks	*So for me explaining to mum about the importance of their relationship which I did but obviously I don't want her having pangs of guilt about it…. it's tricky erm and I suppose the other thing… (HV 10)*	8

	When they don't see what you see	*If you ask the questions and you go back again and they're not picking up on…. there's something really… they can't seem to realise that there's a problem, yeah that can be quite tough, coz then ermm (HV 1)*	7
	A lack of time, training and confidence	*And I guess sometimes it makes me feel like you want to stay there longer, 'cause as health visitors you don't always get long (HV 8)*	9

The felt experience- connection to the personal

This main theme encapsulates the felt experience of participants and how participants own feelings and experiences were evoked from encountering difficulties with the parent-infant relationship.

Powerful feelings evoked

All participants described strong feelings from seeing and hearing about difficulties with the parent-infant relationship, which included sadness for the parent and infant.

Aww, it feels really sad because there's a lovely baby there in the room. And you can see, it's not just about what she's saying, it's about what you see (HV 8)

Feels really sad, feel quite sad for her (HV 10)

Participants also described strong physical reactions. These were as a result of hearing parents talk about their infants negatively, as well as having a gut feeling that there may be difficulties with the relationship.

I felt sick to be honest with you because I couldn't say anything negative to her I had to turn it around and somehow put her in his shoes…..but the thought of a 3-year-old little boy wanting his mammy to go upstairs and give him a kiss night night and tell her she loved him and she wouldn't (HV 2)

And that mother, what she said about her child could be really shocking. It would go into your stomach, she could say really cruel things and that was hard to hear….(HV 5)

But you know when you've got that niggly feeling? That instinct, that kind of gut instinct (HV 9)

Maternal self-elicited

Seven participants reported that being in these situations connected them with their own experiences of motherhood. Some participants highlighted how being with parents, triggered their memories of how difficult it was when they had their own children. This shared experience appeared to lead to an increased understanding and empathy towards parents.

Yes, of course it does, because you sit sometimes, you always sit in the room and you'll remember, "Oh yes, when I had, mum of two and a baby, I remember what that was like." So that is, but it can also bring back negative things as well. I can remember with my own children, how stressed I was about feeding, when I was spoon-feeding them when they were little. And particularly my youngest one was really difficult (HV 3)

I don't think (pause) I just think it gives me a greater depth of understanding of the difficulties and I can understand why she might be feeling like that, because you know I think cause I've experienced that it is hard and it is tiring and you know you do want help from people, everyone's telling you "you've got to bond with your baby" (HV 10)

Participants also acknowledged that their experiences of having children had been significantly different from some parents. This appeared to make it more difficult for them to understand and relate to the parent's experience.

As a person I just can't understand it… as a person me you know I'm one of three and I've got two children and I've never experienced anything like that (HV 2)

You know I've got three of my own children and I absolutely loved having my babies, I loved every minute of it …I was very very lucky you know I had good pregnancies and good deliveries and everything went well so I think I was very ignorant, probably in my own little bubble so when I first started health visiting, I didn't fully appreciate what it feels like or how *it cannot go like that or what could influence women to feel that way about their babies (HV 6)*

Being the one to judge and being judged (a parallel process)

The majority of participants acknowledged how a big part of their role involved making judgements, which included judging the parent-infant relationship. Participants were aware however, that they held assumptions about parents and families that were important to recognise.

You have to be compassionate with the client, but then you know at the same time, so that's why I try and approach in a sensitive manner asking them a bit more how they feel about it before I'm jumping to any conclusions , being open minded not judgemental , because some mums go through a lot of stuff (HV 1)

I'd like go and visit these women and they'd be sat on their sofas on maternity leave in their beautiful houses with their beautiful babies…their beautiful cars on the front drive and they would just be in pieces, they'd be in bits and I'd be like what is going on here, what is going on….. and also, you know the other thing I think I felt a bit mean afterwards coz I think was a bit judgmental like "For goodness sake, how can you be feeling sad when you've got these beautiful babies" (HV 6)

I mean, I was listening to the history at the conference and as much as you want to be non-judgmental, and very open, there was things coming up. For example, there was concerns regarding neglect previously, parents still lived in the same home, concerns around mum not presenting this pregnancy until quite late on (HV 9)

Five participants also described a parallel process of how they felt judged by parents. Participants talked about how some parents may hold negative views of health visitors in general, as well as holding judgements about them more personally.

Horrible, horrible. Because I thought, "She thinks I'm a really rubbish health visitor." And I know mums talk, and my name would have gone round. So my reputation within the acute sector (HV 7)

And we don't get on with everybody, do we? That's the thing, some people, the way that they perceive us, especially maybe health visitors. For some people, they might think, "Oh, they're nosey, they're coming round asking questions" (HV 8)

Maybe you ask yourself "Is it because I'm here? and that's how they're feeling and maybe our relationship she would get more from a different" ...sometimes it might be personalities "Oh how the health visitors coming round, does the health visitor think I've got a problem" (HV 10)

The impact of containing and carrying the burden

This main theme encapsulates the emotional burden placed on participants from recognising and having conversations about the parent-infant relationship. It also highlighted the significant complexities that participants were regularly faced with.

The container and a process of re parenting the parent

Participants described working with high levels of complexity which included working with families where there were concerns related to domestic violence (DV) or parental mental health. There was a sense that the parent-infant relationship was one of many concerns which may lead to it being overlooked.

Families we see (voice breaking), they're so complicated and so complex that sometimes that relationship between a child and the parent gets completely overlooked in a way, because of all the other problems. Like mother's health, or domestic violence……not actually the relationship between the mother and child (HV 5)

As part of their role, participants were faced with tolerating high levels of distress. Participants described being there to listen to parents and appeared to be safe figures who parents could confide and rely on.

Cause I don't want them to feel as though they are left out and no body to turn to in times of need (HV 1)

I'd literally have fifteen minutes of her just crying and telling me over and over again about how her partner used to rape her, and all this kind of stuff. Really horrible, horrible circumstances and then I'd get other calls from her saying, "You're not helping me," and then hanging up on the phone and then not answering me for months at a time. So it was very tricky to deal with (HV 4)

Participants described ways in which they offered containment to parents as part of their role, who were then better able to contain their infants. It was conceptualised that participants may have acted as a nurturing, mother figure for some participants and were almost 're parenting the parent'.

I think sometimes with me she could manage it a little bit better, because I was there, I suppose, I could talk it through…… But we tried to calm the situation together, and me talking through and calming her so she could perhaps calm her child (HV 5)

It's not easy it's not easy…all you can do is draw on those skills and keep trying to role model…there's lots of theories isn't there that if we role model that sort of warmth and empathy and containment that the parents will …like there's some little thing inside the *parents brain which will think "Oh somebody's thinking about my feelings, oh somebody is thinking about my babies feelings" and just maybe tune them in with it a little bit it's not something that you can say to somebody necessarily it's something that you can….it's much more subtle than that…(HV 6)*

And you're that nurturing person that's giving them all this advice where it could have been their mum that would have given that advice (HV 8)

Hopeless, helpless and powerless

A number of participants used words such as hopeless and powerless, when describing working with parents where there were often a range of issues, including difficulties with the parent-infant relationship. Participants saw their role as helping parents; however, described the frustration of trying to help parents who appeared not to want it.

It's a bit dramatic err but yeah it can be feel a bit hopeless or helpless may be a better word you feel like you want to help but they don't want the help (HV 1)

"I'll help you if you want me to, if you don't want me to help you, that's quite difficult" Because where are we gonna go with that? (HV 3)

So it's hard, and you can wake up in the middle of the night. I've had panic attacks from them, because you feel quite powerless and helpless (HV 7)

Left to carry it

Participants described a sense of responsibility for parents when they encountered difficulties, as well as a sense of being left to support parents due to a lack of services or long waiting times.

Well you're a professional and your moral responsibility is too families that you're working with in the community, you can't go out see a problem and walk away you really shouldn't be in the job should you (HV 2)

But then I'm left with it. Until actually it's severe enough it will go to the perinatal mental health team, but their timeframes are longer than actually things like talking therapies sometimes (HV 4)

Participants described a process of carrying families and their difficulties and a sense of this spilling into their personal lives.

Cause you do, sometimes go home and your sitting watching the tele and think "That poor little boy" (HV 2)

We're just carrying other people's problems with us all the time (HV 4)

You carry them for a long time, whether you're working with them or not (HV 7)

How to name the elephant in the room

This main theme captured the difficulties participants had in knowing when and how to start conversations with parents when difficulties were noticed. Participants described a complex and challenging process which seemed to include an aspect of avoiding difficult conversations with parents.

Re-framing

This theme described how as part of their role, participants used strategies such as being positive and normalising when they noticed difficulties. Whilst it was recognised that participants used empathy and understanding to enable parents to reflect on their relationship with their children, this theme was also made sense of as way of not explicitly naming difficulties.

But yeah, they definitely need, you need to draw on a positive. It's a bit like, I'd say the sandwich effect…. So when you have two positives to one negative (HV 7)

And I remember sort of saying to her, "Oh, you're doing great, look at her, she's watching you and she's wanting you to interact with her. Look, she's trying to smile at you or she's trying to coo at you." And then she was saying, "Oh yeah, she is, isn't she?" (HV 9)

I'd also erm you know have open conversations about it being difficult with a baby and that you know it takes time to get to know your baby, that kind of thing (HV 10)

It's not the right time

Participants often described a process of observing difficulties but needing to find the right time to talk about it, which included going back another time and reflected a sense of participants having to deliberate when to introduce conversations.

So erm, I think I would probably have too erm in these cases if they don't disclose but I am seeing something , I'm not necessarily going to say straight away "That I think you have a bonding problem" or something like that because you know I can see that .. I definitely wouldn't do that but then I would try and go back quite soon after (HV 1)

So in the moment it's thinking, "Right, I'm gonna address this but I need to pick the right moment to address it." (HV 8)

Erm yeah and I suppose its …it's parked a little bit and I'll be you know if I observe something maybe not in that contact, I will then sort of go back and talk about relationships maybe …maybe another time erm (HV 10)

Walking on eggshells

Nearly all participants described a process of being careful about how they named difficulties, as well as a sense that it had to be phrased in the right way. This process was conceptualised as a way of avoiding having the conversation, as there was a worry about how it would be received by parents.

Right, I'll be careful about what I say. "How am I phrasing that?" (HV 3)

So I think you don't always talk about the relationship the relationship is a bit like the elephant in the room ...I mean id never say "I'm concerned about the relationship you have with your baby" (HV 6)

You tread carefully, I would say you're walking on eggshells, because you kind of, you can go in with an agenda or a script, "I think I'm gonna do this." (HV 7)

Coping mechanisms

This main theme captures participants coping mechanisms for working in these difficult contexts.

Protecting the self

As a way of managing difficult feelings that were brought up, participants described a range of processes from denying their feelings to blocking them. Participants talked about needing to focus on the parent experience and put themselves aside.

Well I don't live with it, it's not about what it's like for me I don't think "What's that like for me"……… it's not about what it's like for me, that would be wrong for me to sit here and think "What that's like for me" because that's not what my role is (HV 2)

And then you're not focused because your kind of half feeling the way you're feeling and having to block those feelings (HV 4)

Absolutely, but I always think "It's not about me, I will deal with me later". It's just about this mum or this child, and trying to deal with that later on if I have to. (HV 8)

Professionalism -the safety of knowing and having a solution

Participants at times, appeared to find it hard to talk about difficult feelings and experiences and tended to switch to talking about the process of what they did or solutions. This process was made sense of, as a way of distancing themselves as a result of encountering difficulties with the parent-infant relationship and provided a way of managing difficult feelings that were elicited.

That's really, ooh, that really....And sometimes, again as a family nurse we'd get that a lot with young people. (HV 2)

I'm very solution focused, so I think if I'm faced with a barrier, I look at ways of breaking it down (HV 9)

There also appeared to be a sense that 'knowing' things or talking about the 'evidence', made it easier for participants to have conversations about the parent-infant relationship.

When I've kind of got answers, then I think I feel okay about what I say (HV 4)

I sort of adapt it slightly and will quite confidently explain to them about brain development you know obviously it's what the evidence says (HV 10)

Sharing the burden

Participants talked about the importance of talking to colleagues or using supervision as a way of coping, as well as having support from partners or family.

It's very easy to get completely taken in by a client's distress, and it's knowing how you deal with it, isn't it? You have to go and talk to other people about that (HV 5)

I'm lucky enough to go home to a wonderful family, and they can be supportive. Equally when you're a nurse and you have a really bad day; you go home and cry to your partner (HV 8)

Some things help, some things hinder

This main theme highlighted a range of processes that both facilitated difficult conversations about the parent-infant relationship, but also seemed to get in the way.

Relationship both facilitates yet blocks

Most participants talked about the importance of having a relationship with parents in order to be able to have difficult conversations about the parent-infant relationship. Participants reflected needing to build a strong relationship based on trust to helpfully facilitate conversations about the parent infant relationship.

But I don't think, without that relationship, it's very difficult. You need to form some relationship before you can then do very much (HV 3)

It does depend on your relationship with the family. I mean, you have to be professional at all times and be aware that those difficult conversations can make it hard with families that you don't particularly know well. But those that you do know well, it makes it easier because you have a historic relationship with (HV 5)

However there also seemed to be a process of wanting to protect the parent's feelings and their relationship. This pull to protect seemed to get in the way of being able to have the conversation at times. Having a relationship with parents was therefore seen as both something that aided conversations but that also got in the way.

Well you don't want to say it, you don't want to say it, because it's like you're telling her what to do. So it can be really difficult, because you don't want to be the one that's saying that, because you don't want to undermine her, but you know that the baby's really struggling (HV 8)

I *want them to continue to work with us so I don't want them to continue to work with us so I don't want to damage that relationship (HV 10)*

When they don't see what you see

Participants reported that parent's capacity to see the difficulties made it easier for them to have the conversation. Alternatively, when parents lacked insight, this made it harder to be able to talk about the difficulties.

Yeah, and I think that she was very open from the beginning as well. I think it's more complicated when they can't see it. (HV 4)

I think there's both so you will get the parents that you work with who have really good insight that somethings wrong and they will tell you about they will recognise themselves that something is wrong and then you will work with parents who don't even see that its wrong they just…they just think that's how it is…so that's harder almost when your working with parents who for instance will call their child the devil child and not don't even seem to enter their heads that that's probably not a very good thing to think about your baby or describe your baby so that's harder (HV 6)

But it can be really hard when they don't see, you know, they don't see what you see (HV 8)

A lack of time, training and confidence

Participants made reference to a range of factors that made it easier or more difficult to be able to have conversations. Confidence was recognised as a factor that was necessary, in order to be able to have conversations about the parent-infant relationship. Therefore, when participants didn't feel confident, this could lead to conversations not taking place.

And just knowing when to back off. But then having I suppose the confidence as a professional to pick it up again, and not just think, "Oh well" (HV 3)

It's not an area I feel massively confident in……. when I'm kind of a little bit at sea I don't feel erm massively confident and I think erm its ..it was more I genuinely didn't know what was going on (HV 4)

Some participants described how they lacked sufficient time in their role. Whilst participants may have recognised difficulties within the relationship, time constraints acted as a barrier.

I just felt that there was no way that I had the time or skill to be able to unpick that, and that mum's frame of mind (HV 5)

Participants described a range of training experiences. Training was conceptualised as being helpful to participants in feeling able to have conversations about the parent-infant relationship. Training was also linked with participants confidence- those participants who had limited experiences of training appeared less confident in naming difficulties.

I duno whether we need a bit more training (HV 1)

But I've never received any training on how I'm meant to actually work with them. So it does feel uncomfortable, because you're just kind of relying on your own common sense (HV 4)

And it really, really helped. And obviously I had loads of training, the Watch, Wait and Wonder training I did, Understanding Your Baby, Your Baby's Brain (HV 8)

Discussion

The aim of this study was to explore how health visitors make sense of their experiences of talking about difficulties within the parent-infant relationship. In relation to their experience of having these conversations, findings highlighted how they were connected with their own experience and could be left with powerful feelings which led to them developing coping strategies to manage working in these difficult contexts. Participants reflected on the challenges of having conversations and the findings suggested a process of them making sense of the different factors that made it easier or more difficult to have these conversations, including their relationship with parents. There was also a sense that it was sometimes not the right time to name difficulties and that there was a certain way of having conversations which had to be attended to carefully. Health visitors saw their role as containing figures for parents who listened and offered support. They recognised that for many parents they themselves had lacked good enough care and therefore in some ways they were trying to provide parents with relationships they had lacked.

Participants in this study described strong emotional responses when encountering difficulties with the parent-infant relationship. This speaks to existing literature which highlights that working in helping professionals (such as health visiting) can be emotionally challenging (Grant & Kinman, 2014). Those in the nursing profession are regularly faced with difficult situations and recognising the emotional impact this has, is important (McCreight, 2005).

It was notable that participants in this study described being connected with their own experiences of being a mother. For some participants, this led to a shared understanding and increased their empathy. This finding has also been highlighted by mental health nurses who reported that having their own lived experience of mental health, increased their understanding of patient’s difficulties (Oates et al., 2017). For some participants however, they acknowledged having different experiences, which appeared to make it harder to relate to parents.

Research highlights how health visitors work with families experiencing a range of problems, from social and financial difficulties, to relationship and emotional difficulties

(Cody, 1999). This was emphasised in the current study, which highlighted the complexities that participants were regularly faced with. In this study, participants described having to support parents who were experiencing mental health difficulties and had come from challenging backgrounds.

Fraiberg et al. (2003) describe the importance of the parent’s needs being heard, before they can attend to their infants. This echoes findings in this study whereby participants appeared to be ‘re-parenting the parents’ who had lacked good enough care themselves. By attending to the parent’s needs, there was a hope that parents may be able to do the same for their infants. This is resonant with The Solihull Approach which suggests that by professionals containing the parents, a parallel process occurs whereby parents are able to contain their infant (Douglas & Brennan, 2004). This finding does however highlight the challenges faced by health visitors in working with both the parent and the child which is reflective of social workers whose role encompasses holding the rights and needs of the parents in mind whilst safeguarding children (Littlechild, 2020). The literature highlights the importance of building therapeutic relationships and showing empathy whilst also actively monitoring risk and ensuring that the needs of the parents don’t overshadow the needs of the child (Tuck, 2013).

In this study, there appeared to be an avoidance of having conversations about the parent-infant relationship. Participants reported having to choose their words carefully, as well as needing to choose the right moment to talk about the difficulties. One way of understanding this avoidance is reflected in existing research, which suggests that having difficult conversations can lead to distress in professionals (Martin et al., 2015) and therefore lead to them being avoided (Miller et al., 2004).

There is a need for professionals in health care settings to be able to manage their emotions during difficult conversations. Professionals may use self-care strategies outside of work, such as exercising as well as getting support from their team (Luff et al., 2016). In this study, participants reported the importance of talking with colleagues and using supervision as a way of offloading. Having support from peers in the workplace has been found to reduce burnout (Jenkins & Elliott, 2004) and was therefore seen as an important protective strategy.

Participants also described a process of blocking their feelings as well as having to detach themselves from situations. Nurses working in neonatal units report similar strategies and describe having to cut off from their emotions, in order to remain professional at work (Puia et al., 2013). Working in helping professions requires a certain level of detachment (Lyth, 1988) and one way of understanding these strategies is through a psychoanalytic lens. Psychoanalytic theory posits that individuals develop defence mechanisms as a way of protecting the self from having to experience psychic pain (Andrews et al., 1993; de Board, 1978). As well as a denial of feelings, participants also used humour as a way of managing difficult feelings or experiences during interviews, which may be seen as another defence (American Psychiatric Association, 1994).

In this study, there was a tendency for participants to switch to the process as well as focusing on solutions. Furthermore, some participants described how they felt comfortable to have conversations when they ‘knew’ things and could rely on what the evidence says. This ‘professionalism’ was conceptualised as a protection to participants and fits with existing research highlighting that as a way of managing working with grieving families, nurses focus on completing administration and practical tasks (Mander, 2007).

A number of factors were described by participants that were framed as aiding or hindering talking about difficulties, as well as working with parents where difficulties had been identified. In this study, participants described the importance of having a relationship with the parent before being able to name difficulties. This is consistent with literature around starting conversations about PMHPs, which highlights professionals' beliefs about needing to have formed a relationship first with parents (Higgins et al., 2018).

As well as the relationship facilitating conversations, it was also conceptualised as a block to having conversations. Participants in this study described wanting to protect the parents and their relationship with parents. This finding is in line with a previous study into health visitors' experiences of using a tool to assess the parent-infant relationship, which found an avoidance of sharing the tool due to concerns over damaging their relationship with parents (Pettit, 2008). Health visitors in Pettit study also reported time constraints as a barrier which was also noted in the current study.

Some participants identified that they had not received adequate training in relation to the parent-infant relationship, which is consistent with previous research (McAtamney, 2011). There was a sense that some felt out of their depth, which appeared to relate to participants lacking confidence to be able to address difficulties. Participants with more experience and training seemed more comfortable to have conversations about difficulties with the parent-infant relationship. Factors such as lack of training and confidence are also recognised as barriers to professionals addressing other areas such as PMHPs (Byatt et al., 2012).

Limitations

As a result of difficulties with recruitment, participants were recruited from different areas of England. As such, participants worked in different settings where their day to day roles varied. Participants also differed in relation to their experience of training in relation to the parent-infant relationship and IMH. Experiences ranged from no training at all, to having completed a masters in IMH. Moreover, given that recruitment was initially difficult, it is possible that there was a recruitment bias as to who agreed to take part in the study. Participants may have had a particular interest in the area, as well as feeling as though they had the time to commit to being interviewed.

Recruitment difficulties were important to reflect on. The researcher was a trainee psychologist conducting research into health visiting practices and may have therefore been viewed as an ‘outsider looking in’. This may have brought up a range of feelings for potential participants which may have included worries about the intention of the research and a sense of feeling exposed.

An additional limitation is the unavoidable influence of the researcher. First of all, the interview schedule was developed by the researcher, who during interviews followed up on areas of interest. Whilst quality assurance measures were undertaken, such as the researcher having a bracketing interview as well as sharing developing themes with a supervisor, the researcher’s interest and beliefs may have still impacted the analysis process.

It is also important to highlight the position of the researcher as a trainee clinical psychologist. The interview may have created anxieties in participants, with them feeling the need to answer in a certain way, or to come across in a certain light. As interviews were recorded, this may have also led to people not speaking as freely. This was alluded to, by a number of participants at times using humour to state they were mindful of being recorded.

Finally, all of the participants in this study were female. Whilst this is representative of the profession of health visiting (Craig & Adams, 2007) and provides a homogenous sample, findings are therefore limited to women’s experiences. It is also important to highlight that whilst the aim of the study was to understand health visitors’ experiences of talking about difficulties with parents, their experience was predominantly of working with the mother. Furthermore, the majority of participants identified as white British and it would have been helpful to have interviewed health visitors from a range of ethnic backgrounds.

Clinical Implications

This study highlighted health visitors' experiences of working with families where there are difficulties with the parent-infant relationship and other complexities such as mental health difficulties and DV. In this study health visitors seemed to be left with a significant burden in holding so much complexity. In order to minimise the risk of experiencing both secondary trauma and 'compassion fatigue' (Adams et al., 2006), it is important that health visitors feel supported in their work. Health visitors would benefit from opportunities to engage in reflective practice, which would enable them to reflect on difficult situations and make sense of them (Clarke & Graham, 1996).

Research highlights how nurses asking questions about DV for example, can connect them with their own experiences of DV and trigger difficult memories (Webster et al., 2006). It is possible that working with parents where there are a range of complexities, may connect health visitors with their own histories (including being parented and parenting) or have an emotional impact on them. As health visitors increasingly step into more therapeutic roles, for example offering CBT to women experiencing PMHPs (Brown & Reynolds, 2014), accessing counselling or therapy may be beneficial.

Whilst health visitors in this study saw their role as talking about difficulties as well as supporting and listening to parents when difficulties had been identified, some did reflect on a lack of training and confidence. Consultation models exist whereby specialist services offer consultation to primary care services (Medway, 1979). A study reporting on health visitors' experiences of receiving consultations from a specialist parent-infant relationship service (which included clinical psychologists and professionals from health visiting and social work backgrounds), found them to be helpful in increasing health visitors’ confidence as well as creating spaces for reflection (Stefanopoulou et al., 2011).

As well as being offered consultations, additional training could include noticing difficulties with the parent infant dyad, but also considering how to name difficulties if they do arise. As part of their training and practice, psychologists are used to having difficult conversations with clients as well as the wider systems they work in and are therefore in optimal positions to support health visitors in thinking about this further.

Research implications

Future research could explore in depth the themes that arose from this study. One particular theme may be in relation to health visitors’ own experiences of being mothers and how this also intersects with their own experiences of being parented and what may come up for them in the work.

Participants in this study largely spoke about their experiences of working with mothers. This is consistent with existing research, highlighting that services are often focused on the woman (McKellar et al., 2008) which may mean the fathers voice is lost (StGeorge & Fletcher, 2011). Health visitors and midwives however, are in ideal positions to be able to offer support to new fathers (Deave & Johnson, 2008). With this in mind, it would be helpful for future research to focus on health visitors’ experiences of working with fathers, which could include difficult father – infant relationships.

Conclusions

This study explored how health visitors make sense of talking about difficulties with the parent-infant relationship. The benefits of using a qualitative method were highlighted, which allowed for an in-depth exploration of health visitors lived experience in a currently under researched area. Encountering difficulties with the parent-infant relationship connected health visitors with their own feelings and experiences and placed an emotional burden on them. Health visitors were found to use a range of strategies to cope, which included blocking their feelings which was conceptualised as a way of protecting themselves. Whilst health visitors recognised difficulties with parent-infant relationships, there was an avoidance of naming difficulties. A number of factors were found to aid or hinder conversations, including their relationship with parents as well as issues with training and time. A role for psychology is suggested in order to provide health visitors with training, as well as reflective spaces for them to process their own feelings. Future research is warranted to explore health visitors' experiences of working with fathers, as in this study, health visitors primarily talked about their experiences of working with mothers.

References

Adams, R. E., Boscarino, J. A., & Figley, C. R. (2006). Compassion fatigue and psychological distress among social workers: A validation study. *American Journal of Orthopsychiatry, 76*(1), 103-108. doi: 10.1037/0002-9432.76.1.103

American Psychiatric Association (1994). *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV), 4th ed.* American Psychiatric Association, Washington, DC.

Andrews, G., Singh, M., & Bond, M. (1993). The Defense Style Questionnaire. *Journal of Nervous and Mental Disease*, *181*(4), 246–256. https://doi.org/10.1097/00005053-199304000-00006

Appleton, J. V., Harris, M., Oates, J., & Kelly, C. (2013). Evaluating health visitor assessments of mother–infant interactions: A mixed methods study. *International Journal of Nursing Studies, 50(1),* 5-15. doi: 10.1016/2012.08.008

Bailey, M. N. (2009). Parent-child relationships: Developing a brief attachment-screening tool. *Community Practitioner*, *82*(3), 22.

Bowlby, J. (1969). Attachment and loss: Attachment. Attachment. http://doi.org/10.1177/000306518403200125

Bowlby J. (1997). *Attachment and loss (second edition).* London: Random House.

Brown, M., & Reynolds, P. (2014). Delivery of CBT to treat postnatal depression: Health visitors' perceptions. *Community Practitioner, 87*(10), 26-9

Buckman, R. (1984). Breaking bad news: Why is it still so difficult? *British Medical Journal (Clinical Research Edition), 288*(6430), 1597- 1599. doi: 10.1136/bmj.288.6430.1597

Byatt, N., Biebel, K., Lundquist, R. S., Moore Simas, T. A., Debordes-Jackson, G., Allison, J., & Ziedonis, D. (2012). Patient, provider, and system-level barriers and facilitators to addressing perinatal depression. *Journal of Reproductive and Infant Psychology*, *30*(5), 436-449. https://doi.org/10.1080/02646838.2012.743000

Christakis, N. A., & Iwashyna, T. J. (1998). Attitude and self-reported practice regarding prognostication in a national sample of internists. *Archives of Internal Medicine*, *158*(21), 2389-2395. doi:10.1001/archinte.158.21.2389

Clarke, D. J., & Graham, M. (1996). Reflective practice: The use of reflective diaries by experienced registered nurses. *Nursing Review Dublin. 15*, 26-29. http://zu.edu.jo/UploadFile/Library/E_Books/Files/LibraryFile_151614_52.pdf

Cody, A. (1999). Health visiting as therapy: A phenomenological perspective. *Journal of Advanced Nursing*, *29*(1), 119-127.

Cooper, R., Fleischer, A., & Cotton, F. A. (2012). Building Connections: An Interpretative Phenomenological Analysis of Qualitative Research Students' Learning Experiences. *Qualitative Report*, *17*, 1.

Cooper, M. L., Shaver, P. R., & Collins, N. L. (1998). Attachment styles, emotion regulation, and adjustment in adolescence. *Journal of Personality and Social Psychology*, *74*(5), 1380. https://doi.org/10.1037/0022-3514.74.5.1380

Craig, I., & Adams, C. (2007). Survey shows ongoing crisis in health visiting. *Community Practitioner*, *80*(11), 50.

Cummings, E., & Whittaker, K. (2016). Listening visits by health visitors as an intervention for mild-to-moderate postnatal depression or anxiety. *Journal of Health Visiting*, *4*(5), 264-270. DOI: 10.12968/johv.2016.4.5.264

Deave, T., & Johnson, D. (2008). The transition to parenthood: What does it mean for fathers? *Journal of Advanced Nursing*, *63*(6), 626-633. doi: 10.1111/j.1365-2648.2008.04748.x.

De Board, R. (1978). *The psychodynamics of organizations.* London: Tavistock.

Douglas, H., & Brennan, A. (2004). Containment, reciprocity and behaviour management: Preliminary evaluation of a brief early intervention (the Solihull Approach) for families with infants and young children. *Infant Observation*, *7*(1), 89-107. https://doi.org/10.1080/13698030408401711

Fraiberg, S., Adelson, E., & Shapiro, V. (2003). Ghosts in the nursery: A psychoanalytic approach to the problems of impaired infant-mother relationships. *Journal of the American Academy of Child Psychiatry, 14,*(3), 387 – 421. DOI: https://doi.org/10.1016/S0002-7138(09)61442-4

Giltenane, M., Kelly, M., & Dowling, M. (2015). Public health nurses' (PHNs) experiences of their role as part of a primary care team (PCT) in Ireland. *The Australian Journal of Advanced Nursing*, *32*(3), 6. http://hdl.handle.net/10379/14748

Grant, L., & Kinman, G. (2014). Emotional resilience in the helping professions and how it can be enhanced. *Health and Social Care Education*, *3*(1), 23-34. https://doi.org/10.11120/hsce.2014.00040

Higgins, A., Downes, C., Monahan, M., Gill, A., Lamb, S. A., & Carroll, M. (2018). Barriers to midwives and nurses addressing mental health issues with women during the perinatal period: The Mind Mothers study. *Journal of Clinical Nursing*, *27*(9-10), 1872-1883. DOI: 10.1111/jocn.14252

Howe, D. (1999). *Attachment theory, child maltreatment and family support: A practice and assessment model*. Macmillan International Higher Education.

Iwaniec, D., & Sneddon, H. (2001). Attachment style in adults who failed to thrive as children: Outcomes of a 20-year follow-up study of factors influencing maintenance or change in attachment style. *British Journal of Social Work*, *31*(2), 179-195. https://doi.org/10.1093/bjsw/31.2.179

Jenkins, R., & Elliott, P. (2004). Stressors, burnout and social support: Nurses in acute mental health settings. *Journal of Advanced Nursing*, *48*(6), 622-631. DOI:10.1111/j.1365-2648.2004.03240.x

Larkin, M., & Thompson, A. (2012). Interpretative phenomenological analysis. In A. Thompson, & D. Harper (Eds.), *Qualitative research methods in mental health and psychotherapy: A guide for students and practitioners* (pp. 99-116). John Wiley & Son

Littlechild, B. (2020). Empowering involvement in child-protection processes: Balancing the rights of parents and children in terms of having their voices heard. *Children in Social Work–Selected Problems of Social Work, 7.*

Lotzin, A., Lu, X., Kriston, L., Schiborr, J., Musal, T., Romer, G., & Ramsauer, B. (2015). Observational tools for measuring parent–infant interaction: A systematic review. *Clinical Child and Family Psychology Review, 18*(2), 99-132. DOI: 10.1007/s10567-015-0180-z

Luff, D., Martin Jr, E. B., Mills, K., Mazzola, N. M., Bell, S. K., & Meyer, E. C. (2016). Clinicians' strategies for managing their emotions during difficult healthcare conversations. *Patient Education and Counselling*, *99*(9), 1461-1466. doi: 10.1016/j.pec.2016.06.017

Lyth, I. M. (1988). *Social systems as a defense against anxiety.* http://www.moderntimesworkplace.com/archives/ericsess/sessvol1/Lythp439.opd.pdf

Mander, R. (2007). *Loss and Bereavement in Childbearing*. Routledge.

Martin Jr, E. B., Mazzola, N. M., Brandano, J., Luff, D., Zurakowski, D., & Meyer, E. C. (2015). Clinicians' recognition and management of emotions during difficult healthcare conversations. *Patient Education and Counselling*, *98*(10), 1248-1254. doi: 10.1016/j.pec.2015.07.031.

McAtamney, R. (2011). Health visitors' perceptions of their role in assessing parent-infant relationships. *Community Practitioner*, *84*(8), 33-37.

McCreight, B. S. (2005). Perinatal grief and emotional labour: A study of nurses' experiences in gynae wards. *International Journal of Nursing Studies*, *42*(4), 439-448. DOI:10.1016/j.ijnurstu.2004.07.004

McDonald, G. (2001). *Effective Interventions for Child Abuse and Neglect. An Evidence-based Approach to Planning and Evaluating Interventions*. John Wiley & Sons Ltd, Chichester

McKellar, L., Pincombe, J., & Henderson, A. (2008). Enhancing fathers' educational experiences during the early postnatal period. *The Journal of Perinatal Education* *17*(4), 12-20. doi: 10.1624/105812408X364134

Medway, F. J. (1979). How effective is school consultation? A review of recent research. *Journal of School Psychology*, *17*(3), 275-282. https://doi.org/10.1016/0022-4405(79)90011-6

Milgrom, J., & Westley, D. T., & Gemmill, A. (2004). The mediating role of maternal responsiveness in some longer-term effects of postnatal depression on infant development. *Infant Behavior and Development. 27*(4), 443-454. Doi: 10.1016/j.infbeh.2004.03.003

Miller, J., Donner, S., & Fraser, E. (2004). Talking when talking is tough: Taking on conversations about race, sexual orientation, gender, class and other aspects of social identity. *Smith College Studies in Social Work, 74*(2), 377-392. https://doi.org/10.1080/00377310409517722

Moullin, S., Waldfogel, J., & Washbrook, E. (2014). Baby Bonds: Parenting, attachment and a secure base for children. The Sutton Trust. http://www.suttontrust.com/our-work/research/item/baby-bonds

Oates, J., Drey, N., & Jones, J. (2017). ‘Your experiences were your tools’. How personal experience of mental health problems informs mental health nursing practice. *Journal of Psychiatric and Mental Health Nursing*, *24*(7), 471-479. https://doi.org/10.1111/jpm.12376

Oldfield, V., & Carr, H. (2017). Postnatal depression: Student health visitors' perceptions of their role in supporting fathers. *Journal of Health Visiting, 5*(3), 143-149. doi 10.12968/johv.2017.5.3.143

Pettit, A. (2008). Health visitors' experiences of using a tool in assessing infant attachment. *Community Practitioner*, *81*(11). 23-27.

Pietkiewicz, I., & Smith, J. A. (2014). A practical guide to using interpretative phenomenological analysis in qualitative research psychology. *Psychological Journal*, *20*(1), 7-14. DOI: 10.14691/CPPJ.20.1.7

Puia, D. M., Lewis, L., & Beck, C. T. (2013). Experiences of obstetric nurses who are present for a perinatal loss. *Journal of Obstetric, Gynecologic & Neonatal Nursing*, *42*(3), 321-331. doi: 10.1111/1552-6909.12040

Ranson, K. E., & Urichuk, L. J. (2008). The effect of parent–child attachment relationships on child biopsychosocial outcomes: A review. *Early Child Development and Care*, *178*(2), 129-152. https://doi.org/10.1080/03004430600685282

Reid, K., Flowers, P., & Larkin, M (2005). Exploring lived experience. *Psychologist*, *18(1)*, 20-23.

Shonkoff, J. P., Phillips, D., & National Research Council. (2000). US Committee on Integrating the Science of Early Childhood Development. From neurons to neighbourhoods: The science of early child development.

Shore, R. (1997). *Rethinking the brain: New insights into early development*. New York, NY: Families and Work Institute

Shribman, S., & Billingham, K. (2009). *Healthy child programme: Pregnancy and the first five years of life*. Department of Health. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/167998/Health_Child_Programme.pdf

Slade, A., Grienenberger, J., Bernbach, E., Levy, D., & Locker, A. (2005). Maternal reflective functioning, attachment, and the transmission gap: A preliminary study. *Attachment & Human Development*, *7*(3), 283-298.

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

Smith, J. A., & Osborn, M. (2004). Interpretative phenomenological analysis. The British Psychological Society and Blackwell Publishing Ltd.

Stefanopoulou, E., Coker, S., Greenshields, M., & Pratt, R. (2011). Health visitor views on consultation using the Solihull Approach: A grounded theory study. *Community Practitioner*, *84*(7). 26-30.

StGeorge, J. M., & Fletcher, R. J. (2011). Father online: Learning about fatherhood through the internet. *The Journal of Perinatal Education 20*(3), 154-162. doi: 10.1891/1058-1243.20.3.154

Sutter-Dallay, A. L., Murray, L., Glatigny-Dallay, E., Verdoux, H., (2003). Newborn behaviour and risk of postnatal depression in the mother. *Infancy 4*(4), 589–602. https://doi.org/10.1207/S15327078IN0404_10

Webster, F., Bouck, M. S., Wright, B. L., & Dietrich, P. (2006). Nursing the social wound: Public health nurses' experiences of screening for woman abuse. *Canadian Journal of Nursing Research Archive, 38*(4).136-153.

Wilson, P., Barbour, R. S., Graham, C., Currie, M., Puckering, C., & Minnis, H. (2008). Health visitors’ assessments of parent–child relationships: A focus group study. *International Journal of Nursing Studies, 45*(8), 1137-1147. doi:10.1016/j.ijnurstu.2007.07.006

Winston, R., & Chicot, R. (2016). The importance of early bonding on the long-term mental health and resilience of children. *London Journal of Primary Care, 8*(1), 12-14. doi: 10.1080/17571472.2015.1133012

Yardley, L. (2000). Dilemmas in qualitative health research. *Psychology and Health, 15*(2), 215-228. http://doi.org/10.1080/08870440008400302

Yardley, L. (2008). Demonstrating validity in qualitative psychology. Qualitative psychology: A practical guide to research methods. In, Smith, Jonathan A. (ed.) *Qualitative Psychology: A Practical Guide to Research Methods.* SAGE Ltd, pp. 235-251.

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MAJOR RESEARCH PROJECT

SECTION C: Appendices of Supporting Material

A thesis submitted in partial fulfilment of the requirements of Canterbury Christ Church University for the degree of Doctor in Clinical Psychology

June 2020

SALOMONS INSTITUTE

CANTERBURY CHRIST CHURCH UNIVERSITY

Please note: Any identifying features have been removed to ensure anonymity and maintain confidentiality

Appendix A. CASP checklist for qualitative research

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Appendix B. Appraisal tool for Cross-Sectional Studies (AXIS) (Downes et al., 2016)

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Appendix C. CASP for Randomised Controlled Trials (RCT)

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Appendix D. Table 1: Summary of papers included in the review

+	Authors, date	Relevant aims/hypotheses to review	Participants	Design, measures, analysis	Findings relevant to review
1	Agapidaki et al. (2014). Greece	Explore current practices and perceptions of health visitors (HV) regarding the obstacles and facilitating factors in the detection and management of maternal depression	**Participants**: 13 HV. (Unable to report demographics as information was collated with other professionals) **Sampling strategy:** Purposive sampling	**Design:** Qualitative **Measures:** Demographic information. In depth interviews (approximately 45 minutes each) **Analysis:** Framework analysis	HV refer on to GPs as well as more specialist services if problem more severe; HV need training and education be able to support women effectively
2	Alexandrou, et al. (2018). Cyprus	Explore HVs perceptions on their role in assessing, managing, and supporting mothers with postpartum depression (PPD) and provide an insight for further practice development	**Participants**: 10 HV aged between 33 to 63 years old (M = 43). All female with between 6 to 32 years' experience working in the clinic (M = 15.3 years)	**Design:** Qualitative **Measures:** Demographic information. Semi-structured interviews (approximately 45 minutes each) **Analysis:** Qualitative content analysis	HVs offer counselling as well as building communication channels'; HVs reported the lack of evidence base treatments and protocols for supporting women; HVs need more education in this area; HVs felt that supporting women wasn't their responsibility

3	Almond & Lathlean (2011). UK	Investigate equity in the provision of a public health nursing (PHN) postnatal depression (PND) service	**Participants**: 16 HV aged between 38 to 59 (M = 43.4). Majority white British (N = 14). One HV was Chinese and one HV was mixed race. Years of experience ranged from 2 years to 24 years (M = 13.6 years). Less than half had a degree level qualification or above	**Design:** Qualitative **Measures:** Demographic information. Interviews **Analysis:** Thematic content data analysis	HVs offer listening visits for women with PND; HVs refer women to support groups if difficulties were identified
4	Appley by et al. (2003). UK	To train HV in cognitive behavioural counselling (CBC) and assess its impact on HV attitudes, clinical skills and to assess changes in HV clinical practice post training	**Participants:** 97 HV completed training. No demographics reported.	**Design:** Quantitative. Pre test post test **Measures:** Attitudes towards PND and treatment of it assessed by a series of statements which they were asked to agree or disagree with Counselling skills assessed by 15 HVs taking part in videotaped recordings where they assessed and managed a patient (played by an actor) with PND. HVs	**Clinical practice:** -Increase in number of case files stipulating that women had received interventions: Nonspecific treatment: pre training 8%, post training 9% Cognitive or behavioural elements: Pre training 2%, post training 9% CBC: pre training 0%, post training 6% -Increase in referrals to GP's, mental health services and social services GP's: pre training 4%, post training 5% Mental health services: pre training 2%, post training 4% Social services: pre training 1%, post training 2%

				rated on skills pre and post training. Clinical practice was assessed by HVs case files being scrutinised pre and post training (30 HVs excluded from this part as couldn't provide case files for both periods).	
5	Ashford, Ayers, Olander, (2017). UK	Explore HVs (i) experiences with supporting women with postpartum anxiety in their clinical practice and their (ii) views on currently available support and services for postpartum anxiety	**Participants:** 13 HV. (12 HV completed demographic information) HV's were female aged between 29 and 68 years old (M = 43.5). 10 HV's were white, 1 HV was white Irish, and 1 HV was black/African/Caribbean. HVs had between 6 months to 25 years' experience (M = 10.32). 2 HVs had a degree in therapeutic counselling. 2 HVs were PMH champions. 1 was a specialist HV for parental mental health.	**Design:** Qualitative **Measures:** Demographic information. Semi-structuredinterviews (approximately 30 minutes each) **Analysis**: Thematic analysis	**Key themes:** **Importance of training:** HV aware of some training re PMH and more specialist roles; HV feel that there is a lack of training around PMH and they don't feel equipped **Service usage putting strain on HVs already heavy workload:** Try and see mums as often as possible but this was hard due to high caseloads **Status of current service provision:** Can refer to the GP, IAPT, psychiatric services, PMH services, children's centres; services described as 'patchy' and down to where women live

			Sampling strategy: Convenience sampling		
6	Baldwin & Griffiths (2009). UK	Explores how specialist community public health nurses (SCPHN) record the mental wellbeing of mothers from South Asian communities during the new birth visit	**Participants:** 8 HV with between 2- and 25-years work experience. 4 HV were white British, 3 HV's black African and 1 HV was black British. **Sampling strategy:** Purposive sampling	**Design:** Mixed methods (reporting only on qualitative). **Measures:** Demographic information. Semi-structured interview (lasting no more than 30 minutes) **Analysis:** Quantitative content analysis	7 SCPHN reported they would offer the same information in relation to support services. 1 SCPHN provided additional information to south Asian mothers about support groups and counselling services specific to Asian women.
7	Borglin, Hentzel, Bohman (2015). Sweden	Investigate PHNs perceptions and experiences of mental health	**Participants**: 8 HV with 2 or more years' experience in public health services **Sampling strategy:** Purposive sampling	**Design:** Qualitative **Measures:** Semi-structured interviews **Analysis:** Qualitative 4 step content analysis	HV described that often women just need someone to listen to them HV can offer mums additional supportive meetings if they have mental health difficulties Can refer on to psychologists, as well as suggesting that mum join family groups to help mums feel less alone
8	Brown & Bacigalupo (2006). UK	To determine what processes HV in primary care trusts use to identify PND and the implications these have for practice	**Participants**: 6 HV with between 6 months to 10 years' experience **Sampling strategy:** Purposive sampling	**Design:** Qualitative **Measures:** Semi-structured **i**nterviews **Analysis:** Thematic analysis	Key themes: **Visiting patterns:** Open discussions with no set agenda to specific listening visits based on questions from EPDS **Training issues:** Training in management of PND was limited.

					Experience: experience increased confidence in supporting women with PND
9	Brown & Reynolds (2014). UK	Gain an understanding of HVs views and roles as frontline professionals in delivering cognitive behavioural therapy (CBT) to treat eligible women	**Participants**: 9 HVs **Sampling strategy:** Purposive sampling	**Design:** Qualitative **Measures:** Semi-structured focus group interviews (2 focus groups with 6 HVs in one and 3 HVs in the other group) **Analysis:** Thematic approach utilising 7 stage process of analysis	Key themes: **Appreciation of the CBT approach:** all HV provided detailed explanation of CBT **Intervention:** HVs didn't wish to be referred to as counsellors, preferring 'listener'. HV saw benefit of being able to offer CBT to women **Impact of intervention on health visitors:** HV highlighted high caseloads however **Health visitors' views of a training programme**: Would like training in CBT as in good position to offer to women
10	Chew-Graham et al (2008). UK	To explore the views of HV on the diagnosis and management of PND	**Participants**:14 HV **Sampling strategy:** Purposive sampling	**Design:** Qualitative study embedded within larger trial Sharp et al., 2010) **Measures:** In depth interviews (lasting between 25-67 minutes) **Analysis:** Thematic analysis	Whilst HVs offer visits and support to women, for some HV, PND was low on the agenda with concerns that mums could become reliant on the HV; some HV reported feeling that they had nowhere to refer women on to and weren't able to offer support themselves
11	Clark (2000). UK	To understand whether the Edinburgh Postnatal	**Participants**: 3 HV (all female)	**Design:** Mixed methods (reporting only on qualitative).	**Key themes:** **Practice implications for the use of the EPDS:** Listening visits as a result of high score on EPDS where previously visits would

		Depression Scale (EPDS) a suitable tool for HVs to use in pregnancy to detect low mood and depression		**Measures:** Interviews using a semi-structured guide **Analysis:** Content analysis	not have been offered; HV reported listening visits to be useful and covered a range of things from housing to relationships
12	Cummings & Whittaker (2016). UK	Exploring experiences of HVs in carrying out listening visits to support women with mild to moderate depression and anxiety in postnatal period	**Participants**: 33 HVs- including student and qualified HVs with over 10 years' experience. **Sampling strategy:** Convenience sampling	**Design:** Mixed methods (reporting on both qualitative and quantitative data) **Measures:** Online questionnaire. Semi-structured interviews. **Analysis:** Descriptive statistics using SPSS. Content analysis used on open questions in online survey. Nvivo used to support constant comparative method and to develop themes.	**Quantitative findings** - M = 4 listening visits to each woman - 90% of HVs had been trained in Solihull approach - 88% of HVs valued the role of listening visits - 76% reported feeling confident in delivering listening visits - Over 70% had reported received some training in relation to PMHPs - 30% reported feeling that their HV training provided them with learning around maternal mental health - Training in CBT was suggested by n = 11 HVs **Themes from qualitative findings** **Supporting PMHPs** - Number of factors go into the decision making process as to when listening visits are offered - As a way of preventing referrals to services and offering support whilst women waited for other support - Seen as early interventions and support in recovery

					- Relationship was seen as important in offering support **Workforce preparation** *Confidence* - Confidence associated with having received training - Have some knowledge of simple CBT strategies - Some feel 'out of their depth' *Training* - Need more CBT training and information on different PMHPs *Supporting staff* - Better communication between mental health services would be helpful - HVs need time to be able to offer listening visits and high caseloads act as a barrier in acting visits
13	Elliot et al. (2001). UK	HVs who complete training in two different areas (Stoke & Lewisham) in England will report relevant changes in knowledge, and skills; the number of women with high scores on a	**Participants**: 151 HVs were recruited but only 64 completed both pre and post measures. Stoke HVs had been working as HVs for an average of 1 year. Lewisham HVs had been working as a HV for an average of 6 years.	**Design:** Quantitative. Pre and post design with no control group. **Measures:** Questionnaires on knowledge and skills, training experience. Edinburgh Postnatal Depression Scale (EPDS)[1] at 6 weeks, 3 & 6 months to measure depression symptoms.	**Knowledge and skills**: HVs who completed the training reported higher levels of knowledge and skills post training and this was found to be significant **Depression scores:** Training was associated with a significant reduction in depression scores at 3 and 6 months postnatal.

		self-report measure of depressive symptomatology, will be reduced post training in all sectors in the two different areas in England		**Analysis:** Descriptive statistics. Chi square. Mann Whitney. Wilcoxon.	
14	Glasser et al. (2016). Israel	Assess the contribution of an antenatal nursing intervention to reduce subsequent symptoms of PPD	**Participants**: 40 women aged between 18-47 (M = 30.7), two thirds in the 25-34 age group. 69.4% had post high school education. 67.7% worked outside the home. **Sampling strategy:** Purposive sampling	**Design:** Quantitative. Single group pre- post-test. No control. **Measures:** EPDS[1] to measure depression symptoms (completed pre and postnatally). Demographic data. **Analysis:** Descriptive statistics. Chi square, ANOVA. Pearson correlation. Logistic regression	Women who received the intervention had a greater reduction between antenatal and post-natal scores as measured by the EPDS and all but one had a score less than 10 on the EPDS following the intervention, this however was not statistically significant. There was however a significant difference for the women who had an antenatal score of more than 10 on the EPDS
15	Glavin et al. (2010). Norway	Examine the effect of supportive counselling by PHNs on PPD. Hypothesized that supportive counselling	**Participants**: 228 women aged between 18-43 years old (M = 32.1 years). More primiparous women in EG than CG (52% vs 34%).	**Design:** Quantitative. Pragmatic trial. Experimental group (EG) and Comparison group (CG). **Measures:** Demographic information. EPDS[1]	For women with a 6-week EPDS higher than 10, there was a significant improvement following intervention The effects size between the EG and CD was 0.56 at 3 months and 0.51 at 6 months which are suggested to be large.

		given by PHNs would decrease the depression score for mothers who participated in the experimental group (EG), as compared with the usual care group (CG) when variations in maternal age and parity were taken into account	**Sampling strategy:** Purposive sampling	completed at 6 weeks, 3 and 6 months postpartum. **Analysis:** Descriptive statistics. T-test, chi square, regression analyses.	The number of sessions that women had did not make any difference to the findings.
16	Higgins et al. (2018). Republic of Ireland	To explore PHNs engagement, competence and education needs in relation to perinatal mental health (PMH) care in Ireland	**Participants**: 186 HVs. Majority aged over 45 years (64%). 72% had a postgraduate diploma/masters. 93% were employed in public PHN services. Over half (54.3%) had been in role for more than 11 years.	**Design:** Quantitative. Survey **Measures:** Demographic data. Likert scale and open-ended questionnaire **Analysis:** Descriptive statistics. Independent sample t test. Content analysis.	**Knowledge of PMH:** HVs reported good knowledge in relation to services available to women with PMH difficulties (M = 3.10, SD = 1.01). **Overall skill and confidence**: On a scale between 1 (not at all skilled) and 10 (very skilled), skill in relation to PMH care was rated at M = 5.24 (SD = 1.93). On a similar scale between 1 (not at all confident) and 10 (very confident), confidence was rated as M = 5.24 (SD = 1.96) **Skills in PMH activities:** Using a five point scale (1 not at all skilled, 5 very skilled) HVs reported feeling most confident in developing

					a care plan for women who were experiencing depression (M = 2.96, SD = 1.04) and least confident in developing a care plan for women experiencing voices (M = 2.03, SD = 1.04) and experiencing delusions (M = 2.03, SD = 1.04). **PMH care and practice:** 55% of HVs reported developing a care plan for a woman with a pre-existing mental health diagnosis. **PMH services and guidelines:** 57.5% of HV's reported an absence of policies or guidelines for PMH or were not aware of policies in their service. 55.7% of H's reported having care pathways and 52.1% reported having access to specialist PMH services **Educational and practice priorities:** PMH education was associated with higher self-reported confidence, skill and knowledge. HVs identified needing education on support and counselling skills as well as up to date education on PMH.
17	Holden et al. (1989). UK	To determine whether counselling by HVs is helpful in managing PND	**Participants**: 50 women with a mean age of 26.2 years. 72% of women were multiparous. 47 had permanent partners. Nearly half of women (48%) were from social classes 4 and 5.	**Design:** Quantitative. Controlled, random order trial. **Measures:** Demographic information. Standardised psychiatric interviews and EPDS[1]	After three months 18 (69%) of the 26 women in the treatment group had fully recovered compared with nine (38%) of the 24 in the control group. The difference between the groups was 32% (95% confidence interval 5 to 58). The women who had the counselling showed a statistically significant reduction in mean

			Sampling strategy: Purposive sampling	**Analysis:** Descriptive statistics. Wilcoxons signed rank test. Mann-Whitney test for independent samples.	scores from the first to second interview an all the depression measures. The reduction for the control group was not significant. The difference between the two groups on all the measures was statistically significant.
18	Honey, Bennett, & Morgan (2002). UK	To evaluate the efficacy of a controlled psycho-educational group (PEG) intervention for PND compared with Routine Primary Care (RPC)	**Participants:** 45 women. Women were similar in relation to age (PEG M = 29.30 years, RPC M = 26.48) and socioeconomic status. 83% of women in the PEG were co-habitating compared with 73% in the RPC. 50% of women were primiparous in PEG compared to 59% in the RPC. **Sampling strategy:** Purposive sampling	**Design:** Quantitative. RCT **Measures:** Demographic information. EPDS^1 **Analysis:** Descriptive statistics. T- tests. Chi square. Anova. Logistic regression.	A statistically significant reduction in scores was found for women assigned to the PEG versus RPC. EPDS scores PEG Time 1: M = 19.35 (SD = 4.39) Time 2: M = 14.87 (SD = 5.97) Time 3: M = 12.55 (SD = 4.62) EPDS scores for RPC Time 1: M = 17.95 (SD = 3.95) Time 2: M = 16.95 (SD = 5.44) Time 3: M = 15.63 (SD = 7.28)
19	Jomeen et al. (2013). UK	Explore HVs experiences of the assessment of women with psychological distress and mental health problems across the perinatal	**Participants**: 5 HV **Sampling strategy:** Purposive sampling	**Design:** Qualitative **Measures:** Focus groups discussions (FGD's) consisting of n = 4 HV in each group (3 HV took part in both groups) 2 weeks pre and 8 weeks post training	HVs talked about identifying a problem but not knowing what to do next. Reasons for this included lack of service provision or referral pathways HVs reported feeling under qualified and lacking in confidence to deal with issues

		period in clinical practice		**Analysis:** Thematic analysis	Sense of offering more visits than supposed too
20	Jones et al. (2015). UK	Explore changes in HVs knowledge, confidence and decision making for women with PMHP following a brief training package	**Participants:** 72 qualified and student HVs aged between 20 to 60 years. Years since qualification ranged from 1 to 20 years. 7.6% reported no previous PMH training. 57.5% reported previous training. 12% reported completion of a specialist PMH module. 4 HVs took part in FDGs aged between 38-55 years of age with between 2 and15 years' experience. None had undertaken a specialist PMH module.	**Design:** Mixed methods design. Pre post test design. (reporting on qualitative and quantitative data). **Measures:** Questionnaire (using likert scales). Focus group discussions (N = 4). **Analysis:** Descriptive statistics. Paired t test. Linear models. Inductive thematic analysis.	Quantitative findings: Following the training, increased scores were rated in relation to HVs confidence in managing anxiety and depression and severe PMHPs and these changes were found to be significant. General linear models containing age, years of experience and completion of specialist PMH module found that there was a greater change in HVs confidence to manage anxiety/depression and severe PMHP for those who hadn't previously completed the module. Less experienced HVs also reported a greater improvement in their confidence in managing anxiety/depression and severe PMHPs. Qualitative findings: HVs felt unprepared for the complexity of PMHPs and reported not being counsellors but there to listen HVs identified problems with referral procedures and limited provisions for women with some women not being severe enough for certain therapies.

21	McConnell et al. (2005). UK	Examine how HV understand and make sense of PND	**Participants**: 8 HV aged between 39 to 57 years old. All HV had been qualified between 10 and 28 years. **Sampling strategy:** Purposive sampling	**Design:** Qualitative **Measures:** Interviews **Analysis:** Grounded theory	HVs take on different roles when PND has been identified which include explaining and discussing what it is as well as putting women in touch with their GPs if they have made an informal diagnosis of PND.
22	Morgan (2017). UK	Explore the experiences of HVs in facilitating listening visits	**Participants**: 8 HVs **Sampling strategy:** Purposive sampling	**Design:** Qualitative **Measures:** Unstructured interviews (using a phenomenological approach) **Analysis:** Thematic analysis	Four key themes emerged: **Practitioners' expectations:** HVs reported some challenges in offering facilitating listening visits despite number of years that they had been qualified **Training and education:** No specific training in relation only to listening visits and so would like more training. HVs reported access to a specialist HV for PMH. HVs use a range of skills during listening visits. **Communication:** Communication and trust was seen as important in delivering listening visits as well as being collaborative. Partnership working between services was also seen as important. **Caseload capacity:** Capacity of the HVs caseload was related to practice of listening visits. Safeguarding aspects took priority over everything else. HVs reported that it was

					important to assess whether listening visits would be appropriate for women.
23	Morrell et al. (2009). UK	To evaluate benefits for postnatal women of two psychologically informed interventions by HVs	**Participants**: 408 women (with pre and post scores). Mean age was 30.9 years. The majority were white (93.3%). Over half had history of a major life event (54.3%). A small proportion lived alone (6.3%). **Sampling strategy:** Purposive sampling	**Design:** Quantitative. Prospective cluster trial randomised **Measures:** Descriptive statistics. EPDS[1] Secondary outcomes included Clinical outcomes in routine evaluation-outcome measure (CORE-OM)[2] and State-Trait Anxiety Inventory (STAI)[3] **Analysis:** Generalised linear model with co efficients. Regression	**Six months follow up and analysis for all women randomised:**16% of women in control and 12% of women in the intervention group had a six week score of 12 or more which was significantly different. The result was still significant after factors such as living alone, history of PND was adjusted. **Comparison of CB approach and person-centred approach:** Mean scores were the same at 6 months follow up for both groups. **Secondary outcomes:** Some evidence in favour of the intervention group for some of the secondary outcomes at 18 months follow up.
24	Prendergast & Austin (2001). Australia	To establish whether Early Childhood Nurses (ECNs) can be trained in a modified CBT for PND, and (2) to compare the outcome of women treated with this therapy with 'ideal	**Participants**: 37 women who were well matched on a number of factors including age (M = 32.2 years), weeks post-partum (M = 14), past history of depression (M = 46%). 82% of women in the CBT group were primiparous comparted to 60% in control group.	**Design:** Quantitative. RCT **Measures:** Demographic information. EPDS[1] Montgomery and Asberg Depression Rating Scale (MADRS)[4]. Depression Anxiety Stress Scale (DASS)[5].	Statistically significant difference in baseline EPDS for both the CBT and control group At 6 weeks follow up 82% of the CBT group and 77% of the control had scores less than 10 as measured by the EPDS. No significant difference however was found between the groups on MADRS or DASS either post intervention or at 6 months follow.

		standard care' using nonspecific counselling by ECNs with no additional training	**Sampling strategy:** Purposive sampling	**Analysis:** Descriptive statistics. T test.	At 6 months follow up, mean EPDS scores had reduced from 15.9 to 6.2 in the CBT group and from 13.7 to 7.7 in the control group. 93% of the CBT group and 83% of the control had scores less than 10.
25	Rollans et al. (2013). Australia	Exploring how nurses make sense of two potentially contradictory approaches in practice (use of structured tools as well as a flexible approach)	**Participants**: 83 CFHN's aged between 28 to 62 years (M = 51) and had between 1 and over 20 years' experience.	**Design:** Qualitative. Ethnographic study **Measures:** 5 discussion groups **Analysis:** Thematic analysis	HVs were aware of when they needed to refer women on for further support or assessment. HVs reported having access to services such as social workers, GPs, specialist perinatal infant mental health services. HVs were however less positive about referring to local mental health services.
26	Rush (2012). Australia	Improve understanding of the experiences of maternal and child health (MCH) nurses responding to women at risk of PPD	**Participants**: 8 MCH nurses aged between 40 and 59 with between 4 and 22 years' experience. **Sampling strategy:** Purposive sampling	**Design:** Qualitative **Measures:** Demographic information. In depth interviews **Analysis:** Phenomenological method	MCH nurses felt they had a responsibility to ensure women were offered referrals for support Treatments were described as being internal and external to council and included open sessions, groups, referrals for counselling and mother baby units Open sessions were seen as helpful for women to drop in and chat to a MCH nurse Offering extra visits was dependant on time

					MCH nurses referred to GPs the most Confidence in responding to PPD was linked with confidence
27	Sharp et al. (2010). UK	To evaluate the clinical effectiveness at 4 weeks of antidepressant therapy for mothers with PND compared with general supportive care; to compare outcome at 18 weeks of those randomised to antidepressant therapy with those randomised to listening visits as the first intervention and to assess acceptability of antidepressants and listening visits to users and health professionals	**Participants**: 254 women aged between 18 and 44 years old (M = 29.3). Majority white British (77.8%). Over half (52.3%) in paid employment; 24% in higher managerial, 24% in semi routine, 22% intermediate. 25% of women educated to degree level, 27.5% educated to GCSE level. Over half were not married (55.7%) and majority (72.7%) living with partner. Over half had 2 or 3 children (54.3%). **Sampling strategy:** Purposive sampling	**Design:** Quantitative. A pragmatic two-arm individually randomised controlled trial **Measures:** Demographic information. EPDS[1]. Secondary outcomes included Clinical Interview Schedule Revised (CIS-R)[6] computerised version **Analysis:** Descriptive statistics. Logistic and linear regression.	**Antidepressants vs listening visits:** At 4 weeks, antidepressants were significantly superior to listening visits (women more than twice as likely to have improved if randomised to medication) 18 weeks analysis revealed that the proportion of women with reduced scores was 11% higher in medication group however this was not found to be significant.

28	Tammentie et al. (2013). Finland	The aim of the study was to investigate PHNs interaction with families in the child health clinic setting where the mother is at risk of postnatal depression	**Participants**: 14 PHN with between 1.5 to over 20 years' experience	**Design:** Qualitative **Measures:** Demographic information. Interviews **Analysis:** Constant comparative analysis of grounded theory used as a tool	Encourage parents to think for themselves - PHNs felt that offering information to families was important - Trying to be positive with mums even if difficulties have been identified - Offering practical and concrete help was seen as important - Making referrals to a range of professionals including doctors, psychologist and the mental health office - PHNs reported that trust and openness was needed in manging PND
29	Van Lieshout et al. (2019). Canada	The objective of this pilot study was to determine the feasibility and acceptability of PHN delivered group CBT for PPD and to determine preliminary estimates of effect	**Participants**: 7 women with a mean age of 29.57 years. Most were married (n = 5). Highest level of education ranged from college diploma/certificate (n = 2) to professional degree (n = 1). Women on average had one child. **Sampling strategy:** Purposive sampling	**Design:** Mixed methods (reporting on quantitative data only). Pre-test post-test no control **Measures:** Demographic information. EPDS[1]. Penn state worry questionnaire (PSWQ)[7] **Analysis:** Descriptive statistics thematic analysis for qualitative	**Pre/post changes on the EPDS:** Scores on the EPDS reduced from M = 17.14 (SD = 5.34) pre-CBT to M = 8.67 (2.74) post CBT and this was found to be significant. **Pre/post changes on PSWQ**: Scores on the PSWQ reduced from M = 63 (SD = 10.33) pre-CBT to M = 54 (SD = 12.15) post CBT and this was found to be significant. **Pre/post changes for health care visits:** Health care visits reduced from M = 14 (SD = 6.86) pre-CBT to M = 3.43 (SD = 2.94) post CBT and this was found to be significant.

[1]Edinburgh Postnatal Depression Scale (EPDS, Cox, Holden, & Sagovsky, 1987); [2]Clinical Outcomes in Routine Evaluation-Outcome Measure (CORE-OM, Barkham et al., 2001) and [3]State-Trait Anxiety Inventory (STAI, Spielberger et al., 1983) [4]Montgomery and Asberg Depression Rating Scale (MADRS, Montgomery & Asberg, 1979). [5]Depression Anxiety Stress Scale (DASS-21; Lovibond & Lovibond, 1995); [6]The Clinical Interview Schedule-Revised (CIS-R, Brugha et al.,1999); [7]Penn State Worry Questionnaire (PSWQ, Meyer et al., 1990)

Appendix E. Table 2: Strengths and limitations of papers included in the review

Authors, date	**Design**	**Strengths**	**Limitations**
Agapidaki et al. (2014). Greece	Qualitative	• Aims defined clearly • Discussion as to why some participants were excluded • Ethical approval and informed consent reported • Good explanation of chosen methodology for addressing aims • Study procedures and analysis clearly reported (including interview questions) • Limitations discussed • Response bias discussed as a limitation • Demographic information reported • Inter coder agreement discussed	• Relationship between the researcher and participants was not discussed • Purposive sampling (bias) • Ethnicity not reported
Alexandrou, et al. (2018). Cyprus	Qualitative	• Aims clearly defined • Ethical approval and informed consent gained from participants • Clear statement of findings • Implications discussed • Limitations discussed • Demographic information reported • Inter coder agreement discussed	• Relationship between the researcher and participants was not discussed • Design methodology was not justified • Limited detail with regards to recruitment strategy and data analysis • Ethnicity not reported
Almond & Lathlean (2011). UK	Qualitative	• Ethical approval and informed consent gained from participants • Study procedures and analysis clearly reported (including interview topics) • Limitations discussed • Implications discussed • Ethnicity reported • Demographic information reported	• Aims could be clearer • Relationship between researcher and participants was not discussed • Most of health visitors were white British/ English • Sampling strategy not stated

		• Process for ensuring methodological rigor described	
Appley by et al. (2003). UK	Quantitative	• Aims defined clearly • Design appropriate for the aims of the study • Limitations discussed	• Sample size not justified • Not known if there were measures for non-responders • Unknown if certain measures had been trialled before • Methods and basic data could be clearer (sampling strategy not stated) • Ethical approval/ consent not discussed • Demographic information not reported • As this was a before and after study- changes may have been as a result of other factors
Ashford, Ayers, Olander, (2017). UK	Qualitative	• Aims clearly defined • Ethical approval and informed consent gained from participants • Study procedures and analysis clearly reported (including interview topics) • Strengths and limitations discussed • Clear statement of findings • Demographic information reported including ethnicity • Inter coder agreement discussed	• Convenience sample used – response bias as to who agreed to take part in the study • Relationship between researcher and participants not discussed • Majority of health visitors were white British
Baldwin & Griffiths (2009). UK	Mixed methods	• Aims clearly defined • Reasons given for why individuals declined to participate • Procedures and analysis described well (including interview topics)	• Purposive sampling • Didn’t comment on the relationship between the researcher and participants • No comment on process of gaining informed consent

		• Two pilot interviews to check suitability of the questions • Ethical approval, confidentiality and anonymity discussed • Limitations discussed • Ethnicity reported • Response rate discussed as a limitation • Validity issues discussed • Demographic information reported	
Borglin, Hentzel, Bohman (2015). Sweden	Qualitative	• Aims clearly defined • Reasons given for why individuals declined to participate • Ethical approvals discussed • Study procedures and analysis clearly reported (including interview topics) • Example given of process of analysis • Process of addressing and minimising bias (subjectivity) • Inter coder agreement • Implications discussed • Limitations discussed • Completed a pilot interview	• Research design not justified • Relationship between researcher and participants not discussed • Purposive sampling • Little demographic information (only that they had 2 years or more HV experience)
Brown & Bacigalupo (2006). UK	Qualitative	• Aims clearly defined and rationale for chosen methodology • Ethical approval and informed consent gained from participants • Commented on recruitment process and minimising bias • Limitations discussed	• Limited demographic information reported (only years' experience) • Interview topics/guide not discussed • Purposive sampling • Funding/ conflicts of interest not declared

		- Study procedures and analysis clearly reported - Inter coder agreement	
Brown & Reynolds (2014). UK	Qualitative	- Aims clearly defined - Ethical approval and informed consent gained from participants - Limitation discussed (only one) - Clinical implications discussed - Study procedures and analysis clearly reported	- No demographic information reported - Interview topics/guide not discussed - Funding/ conflicts of interest not declared - Relationship between researcher and participants not discussed
Chew-Graham et al (2008). UK	Qualitative	- Aims clearly defined - Study procedures and analysis clearly reported (including interview topics) - Discussion of modifications to interview schedule - Commented on process for managing bias (different professionals looking at the transcripts) - Summary of main findings, implications, limitations discussed - Inter coder agreement	- Demographic information not reported - Relationship between researcher and participants was not discussed - Ethical procedures not documented
Clark (2000). UK	Mixed methods	- Role of researcher discussed (professional relationship with interviewees and researchers own views/bias) - Rationale for methods discussed - Ethical approval discussed - Limitations discussed	- Aims not in abstract - Researcher was also interviewed - More information on implications of the research - Small sample size (n = 4) - Informed consent not discussed

		• Study procedures and analysis clearly reported	• Limited demographic information reported - ethnicity not reported • Sampling strategy not stated
Cummings & Whittaker (2016). UK	Mixed methods	• Rationale for use of qualitative discussed • Ethical approval and informed consent gained from participants • Recruitment strategy and process of analysis discussed • Implications discussed	• Aim described in the abstract but not main body • No limitations discussed • Relationship between researcher and participants not discussed • Limited demographic information reported- ethnicity not reported • Low number of participants completed interviews (n = 3) • No discussion with regards to bias • No measures for non-responders
Elliot et al. (2001). UK	Quantitative	• Aims were clearly outlined • One of the measures used was piloted prior to study • Depression was measured using validated tool • Study procedures were clearly outlined • Limitations were considered in the discussion	• Sample size was not justified • Some of the measures were not checked for validity and reliability • Ethical approvals and gaining informed consent were not discussed • Limited demographic information - ethnicity not reported
Glasser et al. (2016). Israel	Quantitative	• Aims clearly defined • Demographic information reported • Sample closely represented target population • Used a validated tool to measure depression • Basic data described well • Measures for non-responders were reported and no differences found • Limitations reported in discussion	• Sample size was not justified • Sample size relatively small, limiting generalisability • No control group • High rate of refusal to complete measures may indicate selection bias

		• Ethical approval discussed and informed consent gained	
Glavin et al. (2010). Norway	Quantitative	• Aims clearly defined • Measures for non-participating mothers reported and no differences were found • Sample size calculation reported • Validated tool used to measure depression • Ethical approval discussed • Limitations reported in discussion • Demographic information reported • Participants generally well matched	• Participants were not randomised which could have led to bias • Gaining informed consent not explicitly discussed • Ethnicity not reported
Higgins et al. (2018). Republic of Ireland	Quantitative	• Aims clearly defined • Survey was reviewed prior to its use in order to establish face validity • Basic data was described well • Limitations reported in discussion • Ethical considerations discussed • Demographic information reported	• Sample size was not justified • Not able to calculate response rate • Not able to tell whether the sample obtained was representative of target sample • Self-report measures may lead to social desirability bias and not able to confirm accuracy of findings • Ethnicity not reported
Holden et al. (1989). UK	Quantitative	• Demographic information reported • Validated tool used to measure depression • Parts of the study were subject to blinding • Implications discussed • Participants randomly allocated • Participants generally well matched • No differences between participants who entered and completed the study	• Aim only reported in abstract • Relatively small sample size • Sample size not justified • Details not given for non-responders • No discussion of ethical approvals or gaining informed consent • Ethnicity not reported

Honey, Bennett, & Morgan (2002). UK	Quantitative	• Demographic information reported • Participants were randomised • Recruitment strategy discussed • Validated tool used to measure depression • Follow up data for non-completers collected	• Aim reported in abstract not main text • No discussion of ethical approvals or gaining informed consent • No limitations reported in the discussion • Ethnicity not reported • Sample size not justified • Participants in the two groups differed on a range of variables
Jomeen et al. (2013). UK	Qualitative	• Aims clearly defined • Ethical approval and informed consent gained from • Limitations discussed • Process of managing bias during analysis discussed • Inter coder agreement and role of researcher in analysis discussed • Rationale given for methodology design • Implications discussed	• More information needed on recruitment strategy • Small sample size and 3 health visitors participated in both of the focus group discussions • Relationship between researchers and participants not discussed • Demographic information not reported - ethnicity not reported
Jones et al. (2015). UK	Mixed methods	• Aims clearly defined • Demographic information reported • Ethical approvals discussed and process of gaining informed consent • Methods and analyses described • Limitations discussed • Inter coder agreement • Process for ensuring credibility of qualitative data was discussed	• Ethnicity not reported • Relationship between researchers and participants not discussed (for qualitative aspect) • Sampling strategy not stated • Sample size not justified • Details for non-responders not described
McConnell et al. (2005). UK	Qualitative	• Aims clearly defined • Ethical approval and informed consent gained from	• Ethnicity not reported • No implications discussed

		• Justification given for methodology • Procedure and analysis reported (including interview topics and sub categories of data analysis) • Limitations discussed • Demographic information reported	• Relationship between researcher and participants not discussed • Funding/conflicts of interests not discussed
Morgan (2017). UK	Qualitative	• Aims clearly defined • Justification for methodology discussed • Lived experience of researcher described and process for ‘bracketing’ bias • Relationship between researcher and participants discussed • Detailed description of ethical approvals and considerations • Limitations and implications discussed	• Non probability sampling • Limited demographic information reported (only years qualified) • Funding/conflicts of interests not discussed
Morrell et al. (2009). UK	Quantitative	• Aims clearly defined • Validated tool used to measure depression • Demographic information reported including ethnicity • Participants were randomised • Recruitment process discussed • Sample size calculations reported • Participants generally well matched in control and intervention group • Measures for non-responders and no completers • Blinding discussed • Large sample size	• Unable to blind participants or health visitors to group assignment • High rates of attrition

		• Strengths and limitations reported in discussion • Ethical approval discussed	
Prendergast & Austin (2001). Australia	Quantitative	• Aims clearly defined • Recruitment strategy discussed • Validated tool used to measure depression • Participants randomised • Therapy sessions were taped and a number were analysed • Participants were well matched in the two groups • All participants who entered the study completed • Demographic information reported	• Ethical approvals and process of gaining informed consent not reported • Limitations not reported in discussion • Process for blinding not discussed • Ethnicity not reported • Sample size not justified
Rollans et al. (2013). Australia	Qualitative ethnographic	• Aims clearly defined • Ethical approval and gaining consent discussed • Clear study procedures and analysis described (including focus group questions and process for checking reliability when analysing data e.g. inter coder agreement) • Limitations reported in discussion	• Limited demographic information reported – ethnicity not reported • Relationship between researcher and participants not discussed
Rush (2012). Australia	Qualitative	• Aims clearly defined • Justification for methodology discussed • Ethical approval and confidentiality discussed • Procedure and analysis reported • Limitations and implications discussed • Participants were sent copies of their original transcripts with themes for their comment and review	• Process for gaining informed consent not described • Ethnicity not reported • Interview topics not reported • Funding/conflicts of interests not discussed

		• Demographic information reported	
Sharp et al. (2010). UK	Quantitative	• Aims clearly defined • Participants randomised • Validated tool used to measure depression • Demographic information reported including ethnicity • Sample size calculation reported • Measures for non-responders described (responders and non-responders similar) • Limitations reported in the discussion	• Limited to women whose first language was English which limits generalisability • Listening visits were not taped • Difficult to know what led to changes as women were able to receive the alternative intervention
Tammentie et al. (2013). Finland	Qualitative	• Aims clearly defined • Process for maintaining confidentiality was discussed Aspects of methodology justified and analysis described • Implications discussed	• More information needed in relation to recruitment and demographic information • Ethnicity not reported • Doesn’t mention gaining informed consent • Limitations not discussed • Relationship between researcher and participant not discussed
Van Lieshout et al. (2019). Canada	Mixed methods	• Aims clearly defined • Ethical approvals and process of gaining consent was discussed • Recruitment strategy and procedures described • Demographic information reported • Validated tool used to measure depression • Limitations discussed	• Low statistical power due to small sample size • No information for non-responders • No control group • Ethnicity not reported

Appendix F. HRA approval letter

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Appendix G. Ethical Approval from Salomons Ethics Committee

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Appendix H. Ethical approval amendments

(Additional NHS sites via HRA)

“This has been removed from the electronic copy”

(Amendments through Salomons ethics panel)

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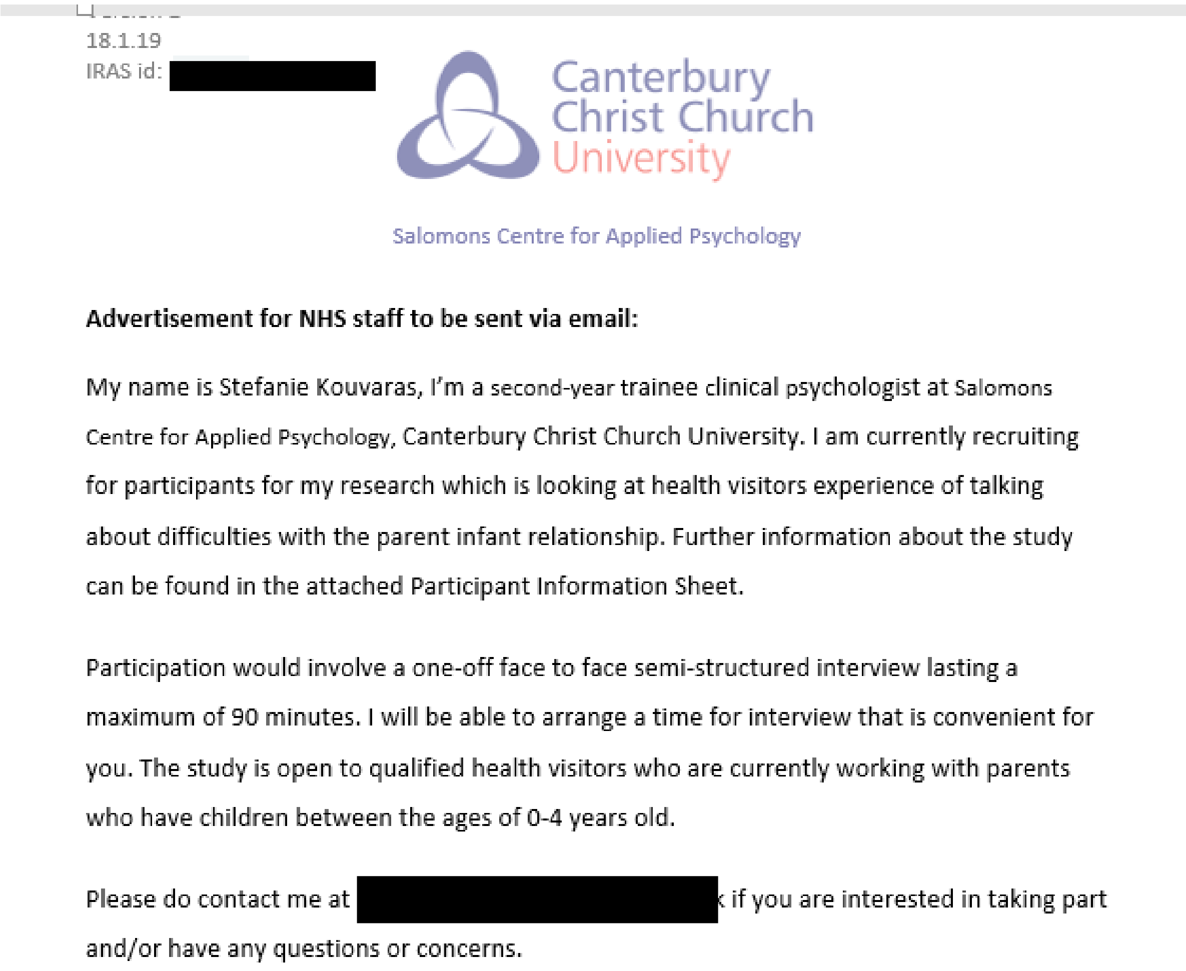
Appendix I. Advertisement sent out to prospective participants via email



18.1.19
IRAS id: [redacted]

Canterbury
Christ Church
University

Salomons Centre for Applied Psychology

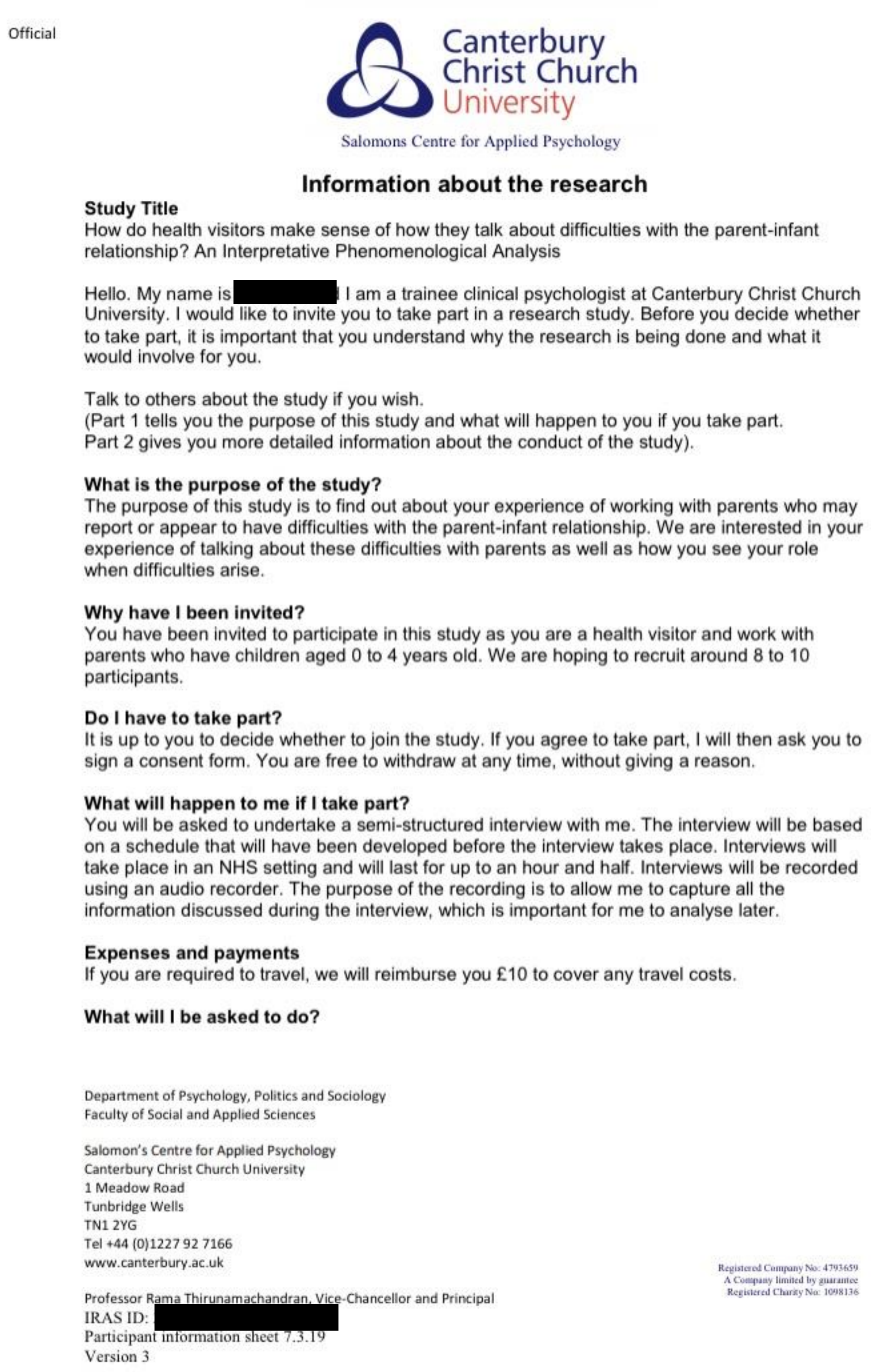
Advertisement for NHS staff to be sent via email:

My name is Stefanie Kouvaras, I'm a second-year trainee clinical psychologist at Salomons Centre for Applied Psychology, Canterbury Christ Church University. I am currently recruiting for participants for my research which is looking at health visitors experience of talking about difficulties with the parent infant relationship. Further information about the study can be found in the attached Participant Information Sheet.

Participation would involve a one-off face to face semi-structured interview lasting a maximum of 90 minutes. I will be able to arrange a time for interview that is convenient for you. The study is open to qualified health visitors who are currently working with parents who have children between the ages of 0-4 years old.

Please do contact me at [redacted] if you are interested in taking part and/or have any questions or concerns.

Appendix J. Participant information sheet



Official

Canterbury
Christ Church
University

Salomons Centre for Applied Psychology

Information about the research

Study Title
How do health visitors make sense of how they talk about difficulties with the parent-infant relationship? An Interpretative Phenomenological Analysis

Hello. My name is [redacted] I am a trainee clinical psychologist at Canterbury Christ Church University. I would like to invite you to take part in a research study. Before you decide whether to take part, it is important that you understand why the research is being done and what it would involve for you.

Talk to others about the study if you wish.
(Part 1 tells you the purpose of this study and what will happen to you if you take part.
Part 2 gives you more detailed information about the conduct of the study).

What is the purpose of the study?

The purpose of this study is to find out about your experience of working with parents who may report or appear to have difficulties with the parent-infant relationship. We are interested in your experience of talking about these difficulties with parents as well as how you see your role when difficulties arise.

Why have I been invited?

You have been invited to participate in this study as you are a health visitor and work with parents who have children aged 0 to 4 years old. We are hoping to recruit around 8 to 10 participants.

Do I have to take part?

It is up to you to decide whether to join the study. If you agree to take part, I will then ask you to sign a consent form. You are free to withdraw at any time, without giving a reason.

What will happen to me if I take part?

You will be asked to undertake a semi-structured interview with me. The interview will be based on a schedule that will have been developed before the interview takes place. Interviews will take place in an NHS setting and will last for up to an hour and half. Interviews will be recorded using an audio recorder. The purpose of the recording is to allow me to capture all the information discussed during the interview, which is important for me to analyse later.

Expenses and payments

If you are required to travel, we will reimburse you £10 to cover any travel costs.

What will I be asked to do?

Department of Psychology, Politics and Sociology
Faculty of Social and Applied Sciences

Salomon's Centre for Applied Psychology
Canterbury Christ Church University
1 Meadow Road
Tunbridge Wells
TN1 2YG
Tel +44 (0)1227 92 7166
www.canterbury.ac.uk

Professor Rama Thirunamachandran, Vice-Chancellor and Principal
IRAS ID: [redacted]
Participant information sheet 7.3.19
Version 3

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A Company limited by guarantee
Registered Charity No: 1098136

You are invited to answer the questions during the interview based on your personal experience of working with parents. However, you can refuse to answer any questions with which you feel uncomfortable and you can stop or take a break in the interview at any time.

What are the possible disadvantages and risks of taking part?
During the interview, sometimes, you might be asked questions about certain topics which are sensitive or may connect you with distress, for example if they touch on issues that are difficult for you at the time of interview. You can refuse to answer any questions which you feel uncomfortable with, or you can stop the interview any time.

What are the possible benefits of taking part?
Whilst there may be no direct benefit to yourself, we hope that by understanding your experiences more, we may be in a better position to help others in the future.

What if something goes wrong?
Any complaint about the way you have been dealt with during the study or any possible harm you might suffer will be addressed. The detailed information on this is given in Part 2.

Will information from or about me from taking part in the study be kept confidential?
Yes. We will follow ethical and legal practice and all information about you will be handled in confidence. There are some rare situations in which information would have to be shared with others. As we are asking professionals to think about their experiences of working with parents/infants, it may be possible that something could come up that is of concern, for example risk of harm to yourself or others. If this arises, the researcher will let you know and will discuss this with their supervisor. If the concern was felt to be serious, this would lead to your line manager being informed. Data that had been collected would not be included in the study.

This completes part 1.
If the information in Part 1 has interested you and you are considering participation, please read the additional information in Part 2 before making any decision.

Part 2 of the information sheet

What will happen if I don't want to carry on with the study?
If you wish to withdraw from the study, you are free to do so at any time without giving a reason. We will ask you if you are happy with us using the data that has been collected up to your withdrawal; however, you are free to say no to this, and we would then destroy your data. We will not collect any further data from you.

What if something goes wrong?

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Faculty of Social and Applied Sciences

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Professor Rama Thirunamachandran, Vice-Chancellor and Principal
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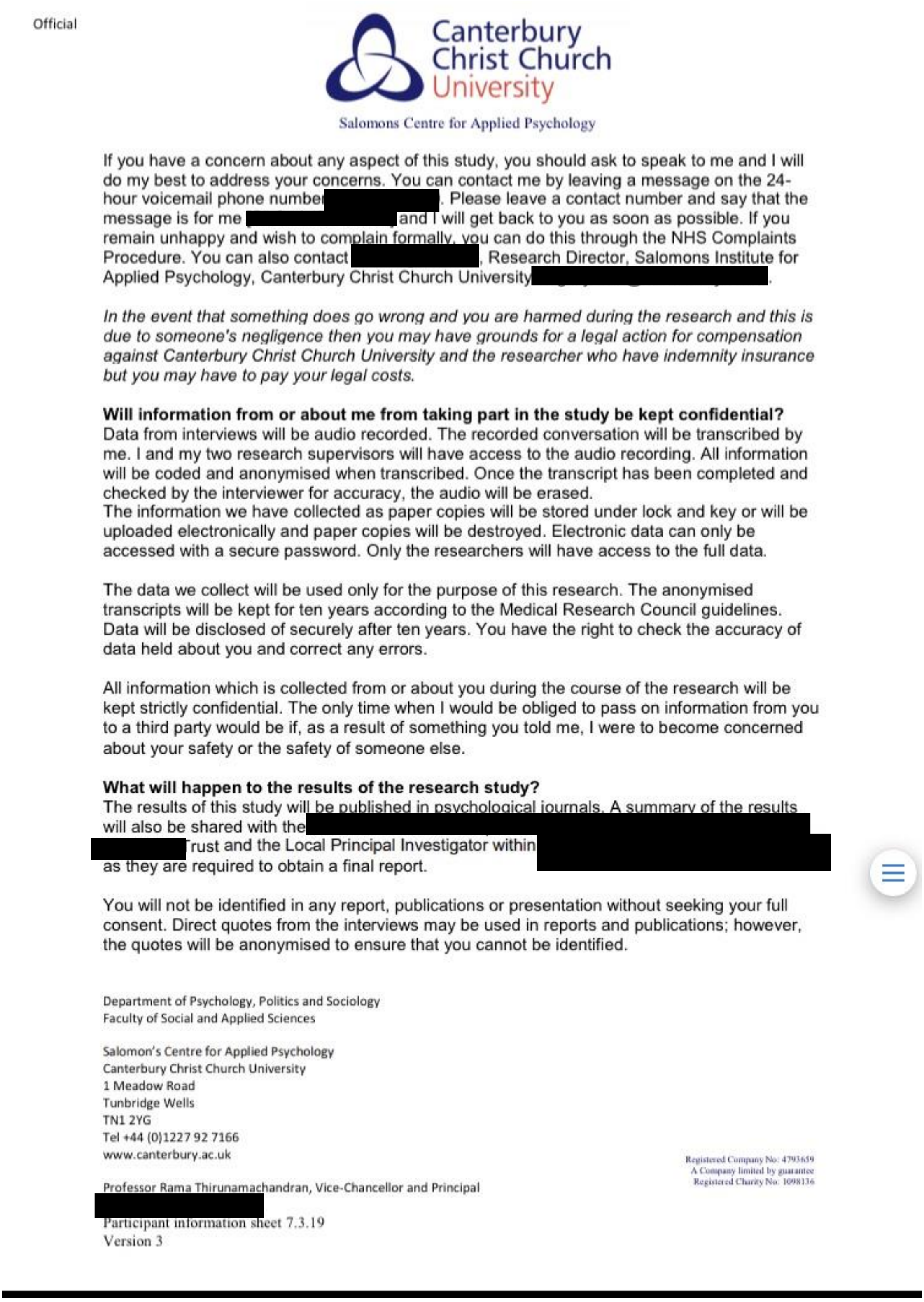

Official

Canterbury Christ Church University

Salomons Centre for Applied Psychology

If you have a concern about any aspect of this study, you should ask to speak to me and I will do my best to address your concerns. You can contact me by leaving a message on the 24-hour voicemail phone number [redacted]. Please leave a contact number and say that the message is for me [redacted] and I will get back to you as soon as possible. If you remain unhappy and wish to complain formally, you can do this through the NHS Complaints Procedure. You can also contact [redacted], Research Director, Salomons Institute for Applied Psychology, Canterbury Christ Church University [redacted].

In the event that something does go wrong and you are harmed during the research and this is due to someone's negligence then you may have grounds for a legal action for compensation against Canterbury Christ Church University and the researcher who have indemnity insurance but you may have to pay your legal costs.

Will information from or about me from taking part in the study be kept confidential?
Data from interviews will be audio recorded. The recorded conversation will be transcribed by me. I and my two research supervisors will have access to the audio recording. All information will be coded and anonymised when transcribed. Once the transcript has been completed and checked by the interviewer for accuracy, the audio will be erased.
The information we have collected as paper copies will be stored under lock and key or will be uploaded electronically and paper copies will be destroyed. Electronic data can only be accessed with a secure password. Only the researchers will have access to the full data.

The data we collect will be used only for the purpose of this research. The anonymised transcripts will be kept for ten years according to the Medical Research Council guidelines. Data will be disclosed of securely after ten years. You have the right to check the accuracy of data held about you and correct any errors.

All information which is collected from or about you during the course of the research will be kept strictly confidential. The only time when I would be obliged to pass on information from you to a third party would be if, as a result of something you told me, I were to become concerned about your safety or the safety of someone else.

What will happen to the results of the research study?
The results of this study will be published in psychological journals. A summary of the results will also be shared with the [redacted] [redacted]rust and the Local Principal Investigator within [redacted] as they are required to obtain a final report.

You will not be identified in any report, publications or presentation without seeking your full consent. Direct quotes from the interviews may be used in reports and publications; however, the quotes will be anonymised to ensure that you cannot be identified.

Department of Psychology, Politics and Sociology
Faculty of Social and Applied Sciences

Salomon's Centre for Applied Psychology
Canterbury Christ Church University
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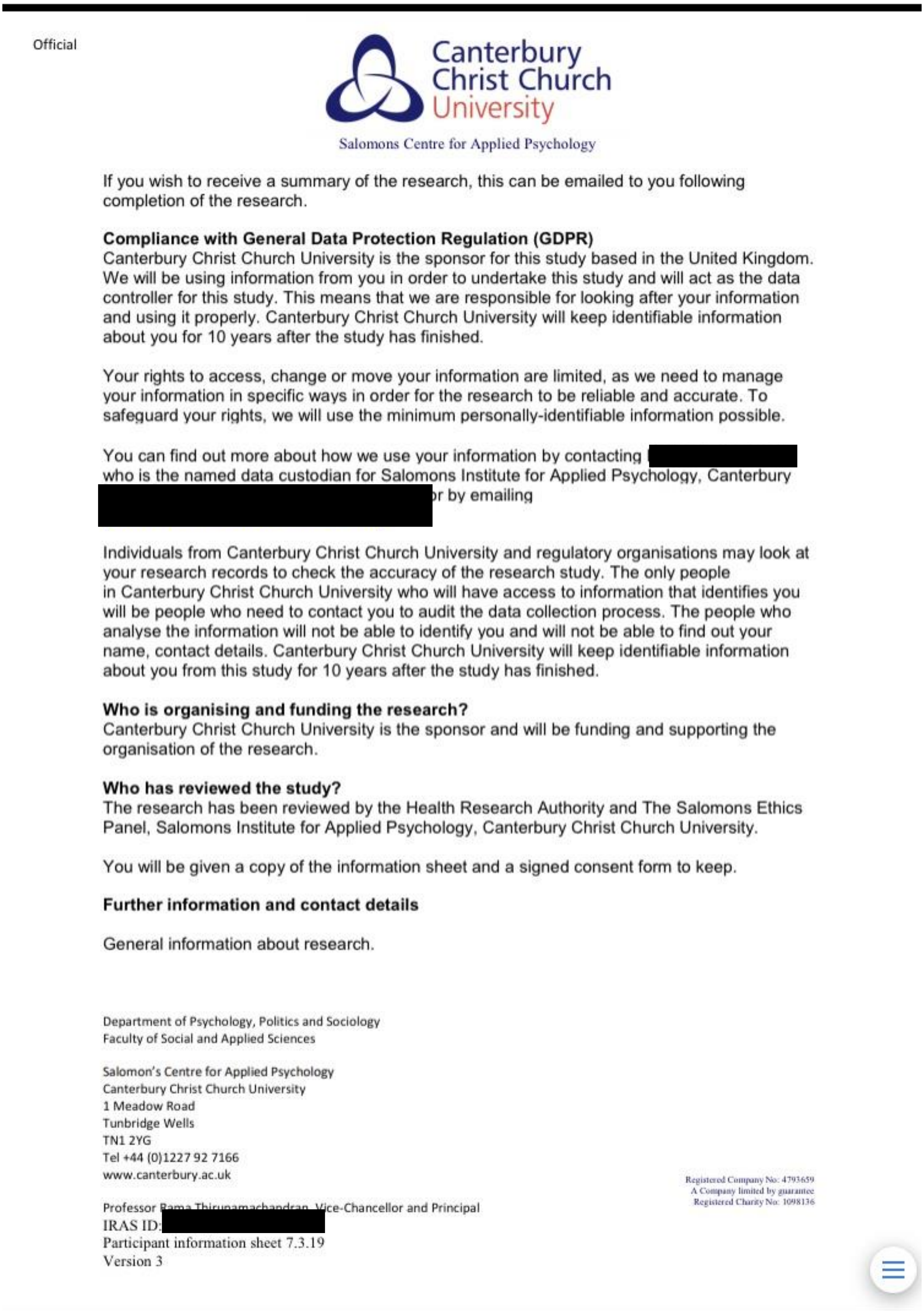
Registered Company No: 4793659
A Company limited by guarantee
Registered Charity No: 1098136

Professor Rama Thirunamachandran, Vice-Chancellor and Principal

[redacted]

Participant information sheet 7.3.19
Version 3



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Canterbury Christ Church University

Salomons Centre for Applied Psychology

If you wish to receive a summary of the research, this can be emailed to you following completion of the research.

Compliance with General Data Protection Regulation (GDPR)
Canterbury Christ Church University is the sponsor for this study based in the United Kingdom. We will be using information from you in order to undertake this study and will act as the data controller for this study. This means that we are responsible for looking after your information and using it properly. Canterbury Christ Church University will keep identifiable information about you for 10 years after the study has finished.

Your rights to access, change or move your information are limited, as we need to manage your information in specific ways in order for the research to be reliable and accurate. To safeguard your rights, we will use the minimum personally-identifiable information possible.

You can find out more about how we use your information by contacting [redacted] who is the named data custodian for Salomons Institute for Applied Psychology, Canterbury [redacted]r by emailing

Individuals from Canterbury Christ Church University and regulatory organisations may look at your research records to check the accuracy of the research study. The only people in Canterbury Christ Church University who will have access to information that identifies you will be people who need to contact you to audit the data collection process. The people who analyse the information will not be able to identify you and will not be able to find out your name, contact details. Canterbury Christ Church University will keep identifiable information about you from this study for 10 years after the study has finished.

Who is organising and funding the research?
Canterbury Christ Church University is the sponsor and will be funding and supporting the organisation of the research.

Who has reviewed the study?
The research has been reviewed by the Health Research Authority and The Salomons Ethics Panel, Salomons Institute for Applied Psychology, Canterbury Christ Church University.

You will be given a copy of the information sheet and a signed consent form to keep.

Further information and contact details

General information about research.

Department of Psychology, Politics and Sociology
Faculty of Social and Applied Sciences

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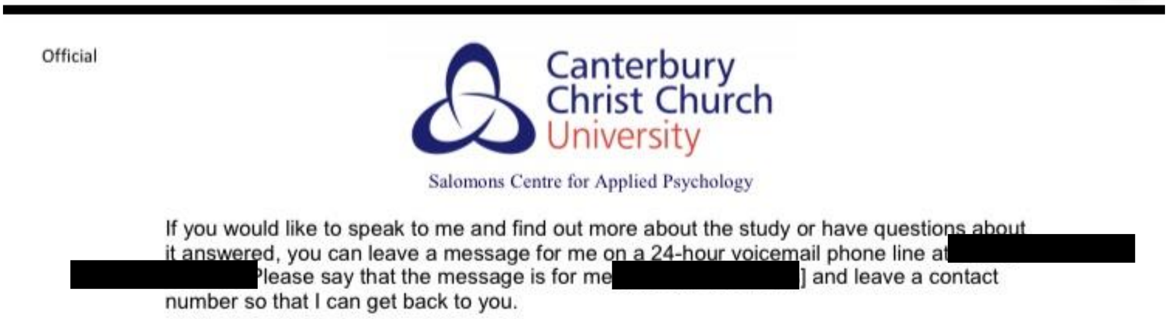

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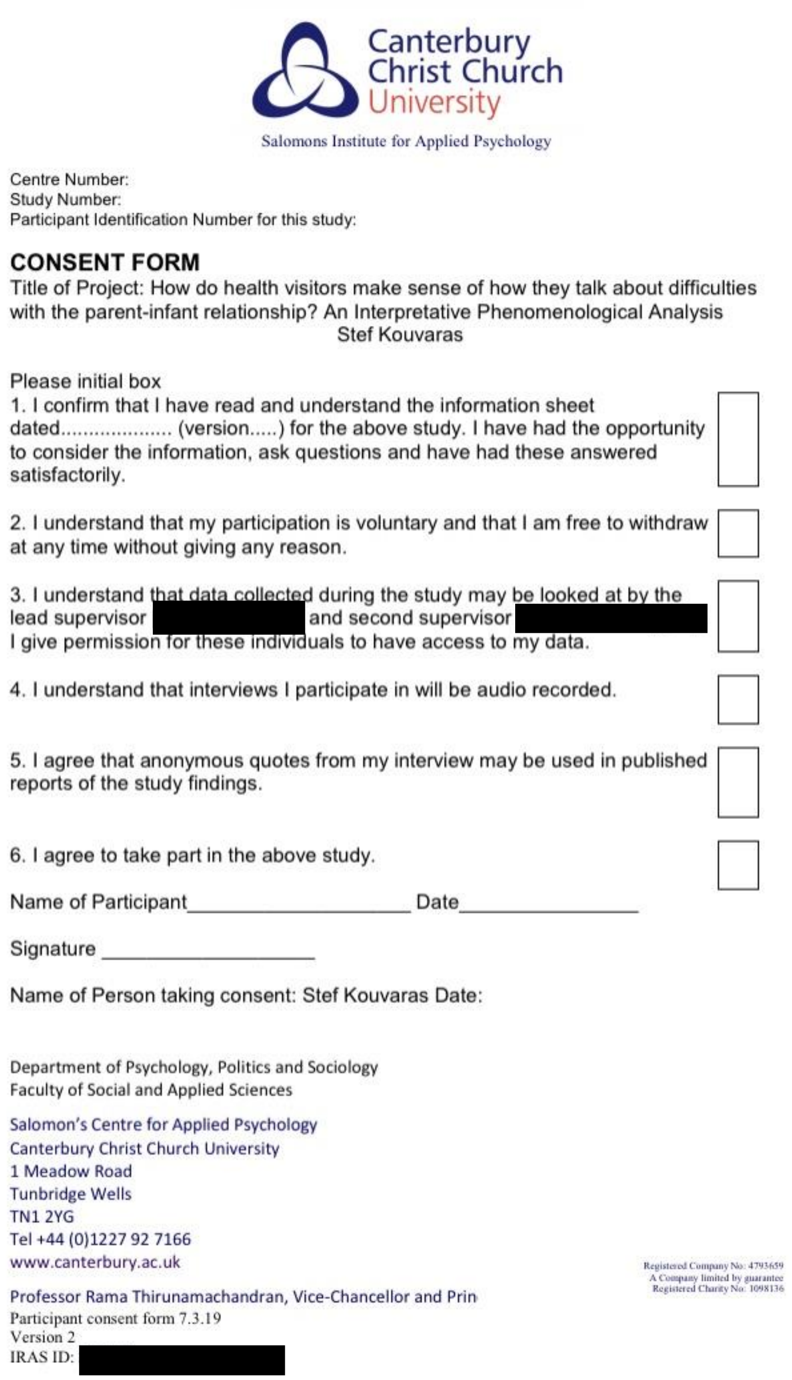
If you would like to speak to me and find out more about the study or have questions about it answered, you can leave a message for me on a 24-hour voicemail phone line at [redacted] [redacted]lease say that the message is for me [redacted]] and leave a contact number so that I can get back to you.

Appendix K. Consent form



Salomons Institute for Applied Psychology

Centre Number:
Study Number:
Participant Identification Number for this study:

CONSENT FORM

Title of Project: How do health visitors make sense of how they talk about difficulties with the parent-infant relationship? An Interpretative Phenomenological Analysis

Stef Kouvaras

Please initial box

1. I confirm that I have read and understand the information sheet dated.................... (version.....) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason. ☐

3. I understand that data collected during the study may be looked at by the lead supervisor [redacted] and second supervisor [redacted] I give permission for these individuals to have access to my data. ☐

4. I understand that interviews I participate in will be audio recorded. ☐

5. I agree that anonymous quotes from my interview may be used in published reports of the study findings. ☐

6. I agree to take part in the above study. ☐

Name of Participant____________________ Date________________

Signature ___________________

Name of Person taking consent: Stef Kouvaras Date:

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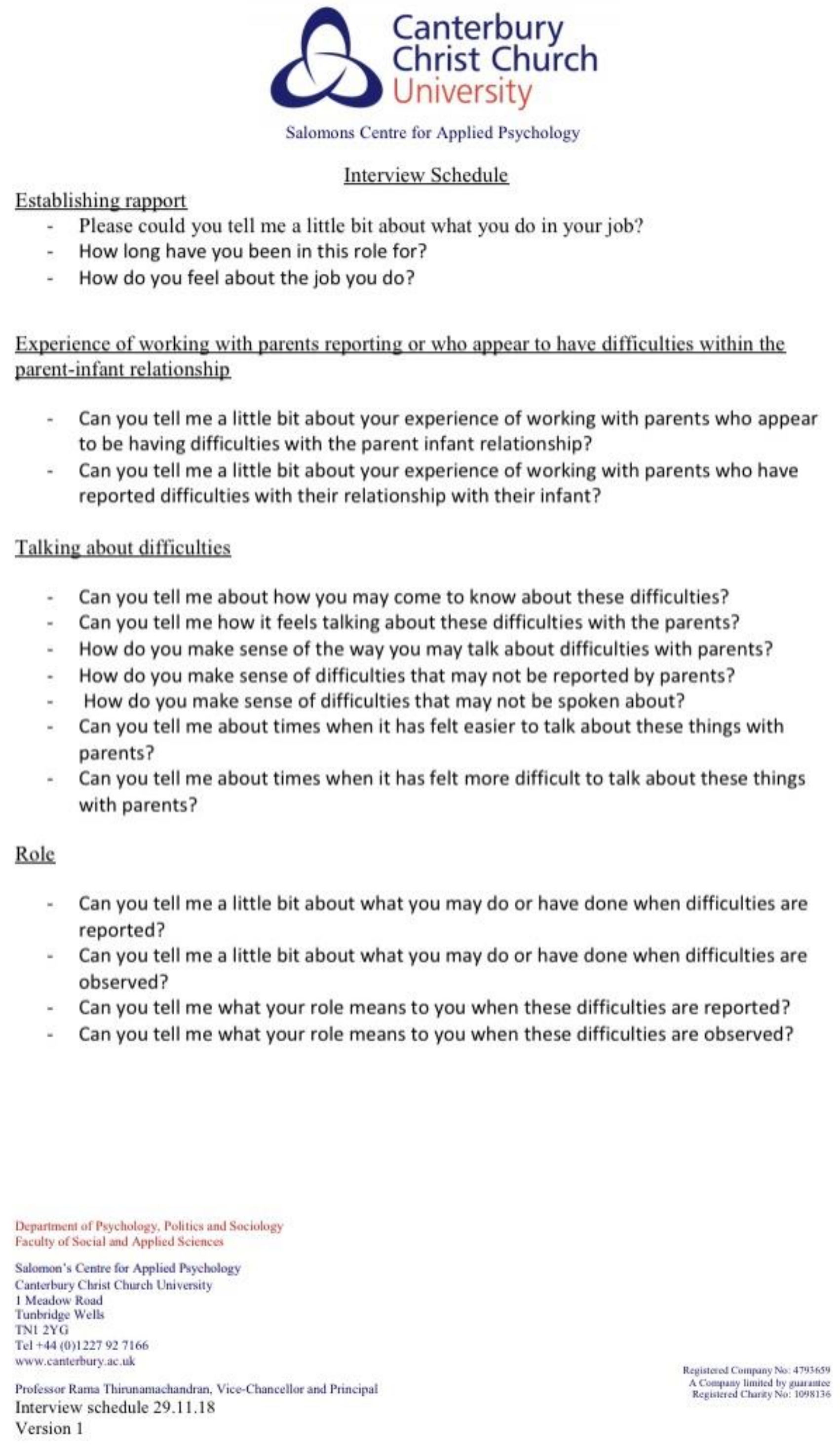
Participant consent form 7.3.19
Version 2
IRAS ID: [redacted]

Appendix L. Interview schedule



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Interview Schedule

Establishing rapport

- Please could you tell me a little bit about what you do in your job?
- How long have you been in this role for?
- How do you feel about the job you do?

Experience of working with parents reporting or who appear to have difficulties within the parent-infant relationship

- Can you tell me a little bit about your experience of working with parents who appear to be having difficulties with the parent infant relationship?
- Can you tell me a little bit about your experience of working with parents who have reported difficulties with their relationship with their infant?

Talking about difficulties

- Can you tell me about how you may come to know about these difficulties?
- Can you tell me how it feels talking about these difficulties with the parents?
- How do you make sense of the way you may talk about difficulties with parents?
- How do you make sense of difficulties that may not be reported by parents?
- How do you make sense of difficulties that may not be spoken about?
- Can you tell me about times when it has felt easier to talk about these things with parents?
- Can you tell me about times when it has felt more difficult to talk about these things with parents?

Role

- Can you tell me a little bit about what you may do or have done when difficulties are reported?
- Can you tell me a little bit about what you may do or have done when difficulties are observed?
- Can you tell me what your role means to you when these difficulties are reported?
- Can you tell me what your role means to you when these difficulties are observed?

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Interview schedule 29.11.18
Version 1

Appendix M. Bracketing Interview Questions and mind map of themes

Questions using Ahern (1999) tips for reflexive bracketing

Pre-interview

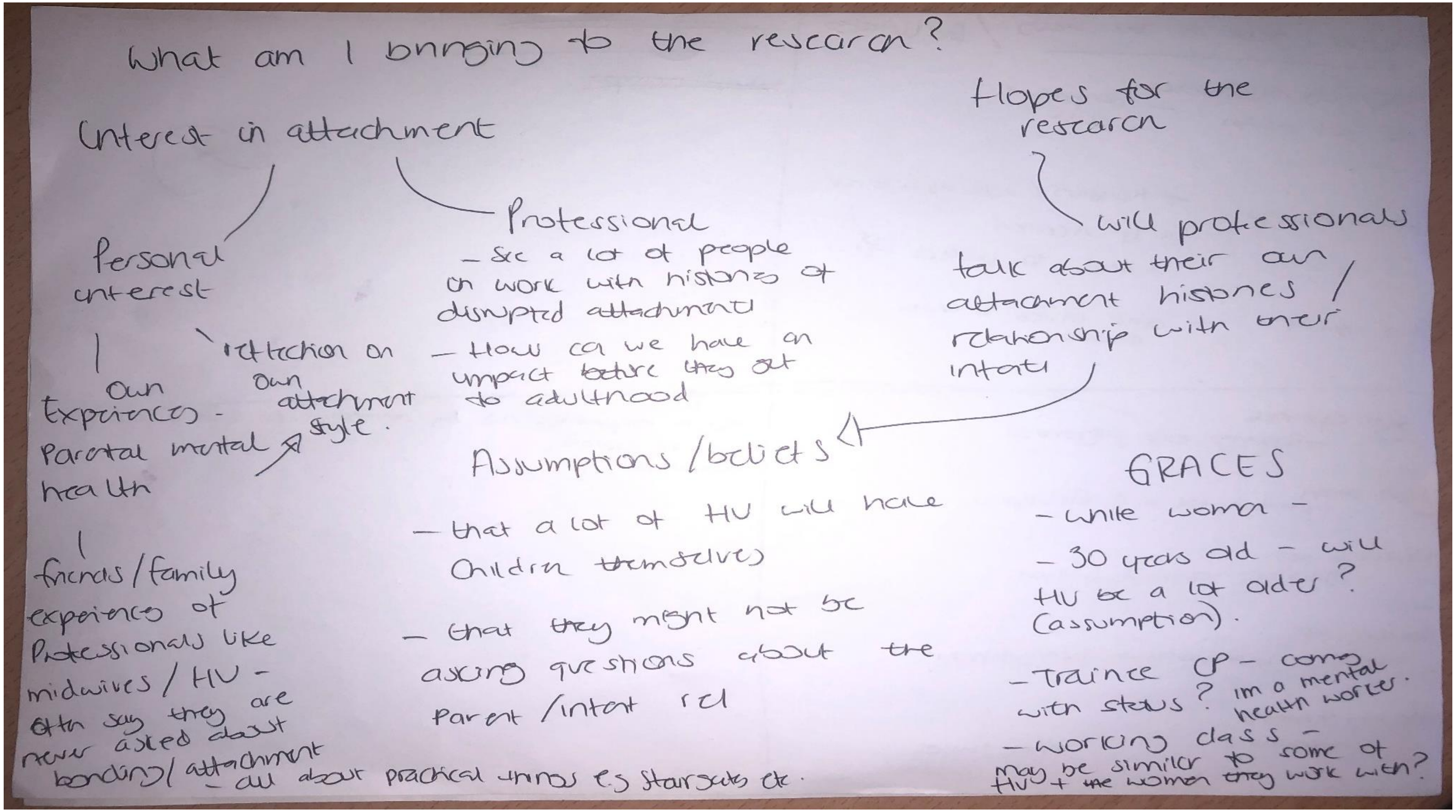
- How did you come to undertake this research?
- What do you think are the similarities and differences between yourself and your participants in terms of GRACES?
- Why do you *think* (or assume) people might take part in your research? Might there be anything problematic about that?
- What do you hope will come of the research? What impact do you hope it will have?
- Have you felt anxiety/annoyance or enjoyment at any point so far?
- Might the results and their publication cause problems for any group?
- How are you reaching participants? Who are the gatekeepers? How might this affect the participants you have access to?
- How do you hope your interviews will go? Are there things you hope to hear? Or don't want to hear?
- Is there anything in your past or your identity that might colour the way you interact with participants/view the data?

Post-data collection

- Is there anything new or surprising in your data collection or analysis? Are you bored?
- Have you experienced any problems?

Post-analysis

- Even when you have completed your analysis, reflect on how you write up your account. Are you quoting more from one respondent than another? If you are, ask yourself why. Do you agree with one person's sentiment or turn of phrase more than those of another? If so, go back to your analysis and check that an articulate respondent has not biased your analysis by virtue of making your analytic task easier. Did you choose to write up the account in the first or third person? Why?
- How do you think your results fit with existing theories and literature? Why do you think that might be?
- In the light of your bracketing, would you do anything differently, or do you need to do anything again?



What am I bringing to the research?

Interest in attachment

Personal interest

Own Experiences - Parental mental health

reflection on own attachment style.

friends/family experiences of Professionals like midwives / HV - often say they are never asked about bonding/ attachment - all about practical things e.g. stairgates etc.

Professional

- See a lot of people in work with histories of disrupted attachment
- How can we have an impact before they get to adulthood

Hopes for the research

will professionals talk about their own attachment histories / relationship with their infant

Assumptions / beliefs

- that a lot of HV will have Children themselves
- that they might not be asking questions about the parent /infant rel

GRACES

- white woman -
- 30 years old - will HV be a lot older? (assumption).
- Trainee CP - comes with status? I'm a mental health worker.
- working class - may be similar to some of HV + the women they work with?

Appendix N. Excerpts from reflective diary

Ethical approval (March 2019)

Happy to have ethical approval now from HRA and Salomons committee. Looking forward to start recruitment!

Meeting at xxxx (March 2019)

Joined a meeting today with senior nurse colleagues at xxxx in order to outline the research. They seemed interested in the research and keen to support with recruitment- feeling hopeful.

Capability and Capacity assessment (April 2019)

Finding it quite difficult getting the necessary procedures in place in order to start recruiting with xxxx. Having to juggle placement as well as responding to different emails is feeling quite challenging- just want to be able to get going now.

Difficulties in recruiting (May 2019)

Recruitment has been difficult- since getting ethical approval have reached out to a number of different HV teams within xxxx– however people not getting back to me. I know people are really busy but feeling a little deflated.

Joining team meeting at (xxxx) (June 2019)

Joined a team meeting today at one of the hubs within xxxxx. Felt as though people weren’t that interested in the research – most staff didn’t even look up at me whilst I was talking about the research. Wondering what may be going on here- time pressures/ burnout? Trying to be understanding however feels quite difficult for people to not even look at me while I’m talking. Perhaps it is a way of defending?

Amendments to ethics (July 2019)

After speaking with my supervisor and manager, I have decided to get an amendment to try and recruit via non-NHS organisations. This has been approved now. Starting to feel a lot of anxiety about not getting any interviews so hope this change in strategy works.

Still no interviews (August 2019)

No interviews lined up yet and my anxiety is increasing! I'm sending emails at all hours of the day which is challenging whilst having to juggle multiple things. Feel lucky to have my partner for support and trying to hold the optimism for me! Spoke with supervisor about how late I can leave it before having to think about changing project- really don't want to have to do this. Feel like all my thoughts are taken up with this at the moment.

First interview (September 2019)

Ecstatic to get first interview – the change in recruitment strategy seems to have paid off! Have a few other people who have emailed their interest also- fingers crossed! Doing the interview was harder than I thought – really felt like a novice and worried about not asking the right questions! Feel like I slip into a therapist role as well a bit too much.

(October 2019)

Feeling a bit more confident with interviews now and feel as though there is some good data coming through! Really interesting how a lot of participants are saying similar things however seem to find it hard to reflect on their experience - finding myself having to ask the question a few times – maybe it's just really hard to be able to think about themselves? I'm wondering what chance- if any- they get to have these types of conversations and reflect in this way.

Last interview (December 2019)

Can’t believe I managed to get the intended 10 interviews! Feeling very thankful to be at this place now given that at one point I thought I would need to change the project entirely. Felt as though I got to quite a personal place with this health visitor and wondered if I pushed too hard maybe? The interviews have made me realise the complexity health visitors are faced with and are kind of having to do a bit of therapy really without the right training. Seems as though they need to be offered more training and space to reflect on all the difficulties, they have to deal with….

January 2020

Transcribing is a really helpful process- noticing how difficult it can be for some health visitors to connect with their own feelings as well as the different things they do to cope day to day. Keep thinking about how lucky I am to get all this training as a CP and space for reflection etc.

March 2020

Struggling with the analysis process- feel like I’ve got lots of themes but struggling to make sense of it all. Worried about not getting it right. Hope things start to click into place soon. Noticing how I have been drawn to some accounts more than others- reflecting on what this is about? Are they more interesting/ do they articulate themselves in a clearer way?

Appendix O. Audit trail process

The following documents were reviewed:

1) A number of un-annotated transcripts – lead supervisor

2) Two complete, annotated transcripts – lead supervisor

3) One document with emerging themes, sub and super ordinate themes – lead supervisor

4) One document with themes and participant quotes – lead supervisor

5) Results section with final sub- and superordinate themes and quotes from transcripts – lead and second supervisor

Appendix P. Coded transcript

“This has been removed from the electronic copy”

Appendix Q. Stage 1 emerging themes and quotes – individual level

Themes	**Quotes**
HV valuable role	P2 hv role is really important
Make a difference/achievement for self	P2 feel it's a job where you can make a difference
Change is slow	P2 its more of a longer term burner thing often
Working with complexity	P3 mum who herself has experienced a difficult upbringing herself or had childhood trauma, for her to parent then is going to be somewhat challenging at times
Role - supporter	P3 so it's a case of trying to support parenting..
Limits to her role / small wins?	P3 chipping away and focusing on the small things erm
Own assumptions/beliefs	P4 making sure mum is making the right choices in the style that shes parenting
Difficulties are noticed	P4/5- 'I could see' 'there was noticeably (sighs)
Obvious difficulties	P5 'was sort of obvious that she was finding it difficult to interact'
Indicators/ things that alert to difficulties	P5 yeah coz she was standing back erm she found it hard to know she couldn't respond to the babies cues of sort of looking at her, baby maybe wanting her to pick her up
Own feelings evoked from seeing difficulties - sadness	P6 Feels really sad, feel quite sad for her
Want to help mum	P6 feel like you want to step in
Strategies used **Difficulties not named directly – being positive**	P6 using positive affirmations to mum
Offering support/ advice without naming the difficulties	P7 suggesting things like oh look how your baby is looking at you Just being really positive

Normalising as a strategy	P7 I'd also erm you know have open conversations about it being difficult with a baby and that you know it takes time to get to know your baby, that kind of thing
Seeing difficulties- connects to her experiences of being a mother (personal experiences)	P7 sadness I suppose for me is because maybe I use my own erm experiences as a mother
Mother identity and hv identity crosses over	P8 how much joy you get back so in my practice having that you know I'm a mum myself and oo I really want it to work for you coz ..and also I suppose that knowledge of my training in terms of how important that attachment is and if its not there the difficulties that might come later
Holding hope	P8 and hope you know I know things change and you know I might observe that one day but actually two weeks later things have settled and things are much better
Connected with own experiences of mother hood- difficult experiences – shared experience – similar	P9 I don't think (pause) I just think it gives me a greater depth of understanding of the difficulties and I can understand why she might be feeling like that, because you know I think coz I've experienced that it is hard and it is tiring and you know you do want help from people, everyone's telling you "you've got to bond with your baby" (HV 10)
Pressures on mums- wants to avoid this on mums (protecting mum?)	P9 everyones telling you you've got to bond with your baby
Uncertainty	P11 almost too much contact but then im not sure..but then you know on the flip side can there be too much?
Hard to connect with feelings	P12 I think I probably felt, without judging her I probably felt does she know how to interact with what her needs are now shes 6 months old
Own judgements- this isn't comfortable	P12 I think I probably felt, without judging her I probably felt does she know how to interact with what her needs are now shes 6 months old
Observing the difficulties	P12 but it didn't look natural and it didn't look comfortable the interaction
Indicators	P13 if mum was erm (pause) like a bit of sort of edge…… was like mum wasn't relaxed,

Is it me?	P13 /14 maybe you ask yourself is it because I'm here and that's how there feeling and maybe our relationship she would get more from a different …sometimes it might be personalities
Anxiety as to how shes perceived	P14 'oh how the HV's coming round does the HV think ive got a problem'
Strategy – be positive **Difficulties cant be named / there too hard to talk about**	P14 think I was like 'oh look shes so happy with you, she is such a smiley happy baby wow' erm it was a bit more like that not so direct
Conversations are hard	P15 its not easy, because….the
Need to protect mum	P15 was coz mum was already nervous about how she would be interacting with baby
Things make it harder	P16 it was slightly tricky coz there was sort of a cultural element as well
Right time for conversations	P1 was then when I found it quite an opportunity to talk to her about you know keeping baby close and how I noticed how much her family were supporting…
Difficult to have conversations	P17 its quite difficult yeah
intrusive	P18 it would be the (pause) erm I suppose its quite intrusive
Hard to connect with feeling	P18 erm whats the feeling erm, how im feeling, im feeling (pause) not feeling sad (pause
Own anxiety raised –	P18 erm maybe slightly awkward if I'm honest
Her Emotions impact on having the conversations	P18 : probably the quality of how I question
Increased self focus **Anxiety raised** **Lacking confidence**	P19 erm maybe how (pause) its perceived, if I'm finding it difficult then it would come across in how I'm saying it which will have an impact on my body language,
Relationship	P 19 will have an impact on the relationship with her
Relationship helps / familiarity **Importance of feeling comfortable**	P20 yeah when you've got a relationship with them, early on its difficult, that's why, when…I suppose its easier and a more comfortable conversation when you have got to know the mum and you've had that conversation before,

Gradual process – takes time	P 20 dripping and building on the conversation so you've started it previously to them having the baby and drip- some questions in
relationship	P20 building trust with the client and a relationship is being built between you..yeah
Barriers- cultural	P21 if mum is I suppose not being (pause) if your observing something and if there's families in the situation or if there's I suppose cultural barriers and sometimes it would be erm (pause)
Importance of sensitivity – respect	P22 coz its respectful to have that conversation with them
Holding mums feelings in mind- Protecting mums feelings	P22 so for me explaining to mum about the importance of their relationship which I did but obviously I don't want her having pangs of guilt about it..its tricky erm and I suppose the other thing…
Practically things get in the way	P23 : erm obviously language barriers, if your using interpreters your not sure if there translating as your saying it so that's practically erm a barrier erm
Slow process	P22 gradual change and gradual conversations
Professionalism – knowing the evidence protects?	P23 will quite confidently explain to them about brain development you know obviously its what the evidence says
Things get parked **Avoided** **Boxed off** **Put off**	P25 erm yeah and I suppose its..its parked a little bit and ill be you know if I observe something maybe not in that contact I will then sort of go back and talk about relationships maybe …maybe another time erm
Right time	P26 indication for me to sort of go back and review erm and then you know at that point
Difficulties not named	P26 talk about how she could erm you know encourage talk about baby massage and things like that
Hard to connect with own feeling – detached from feelings?	P27 erm I feel that I've identified something that I can't leave unaddressed so I suppose I feel (long pause) erm I feel like I …oo I need to go back and figure that out or erm I don't know how I feel (laughs)
Lack of space for herself in the work **Impact on her**	P28 yeah so I'll…yeah..maybe I haven't given it enough thought

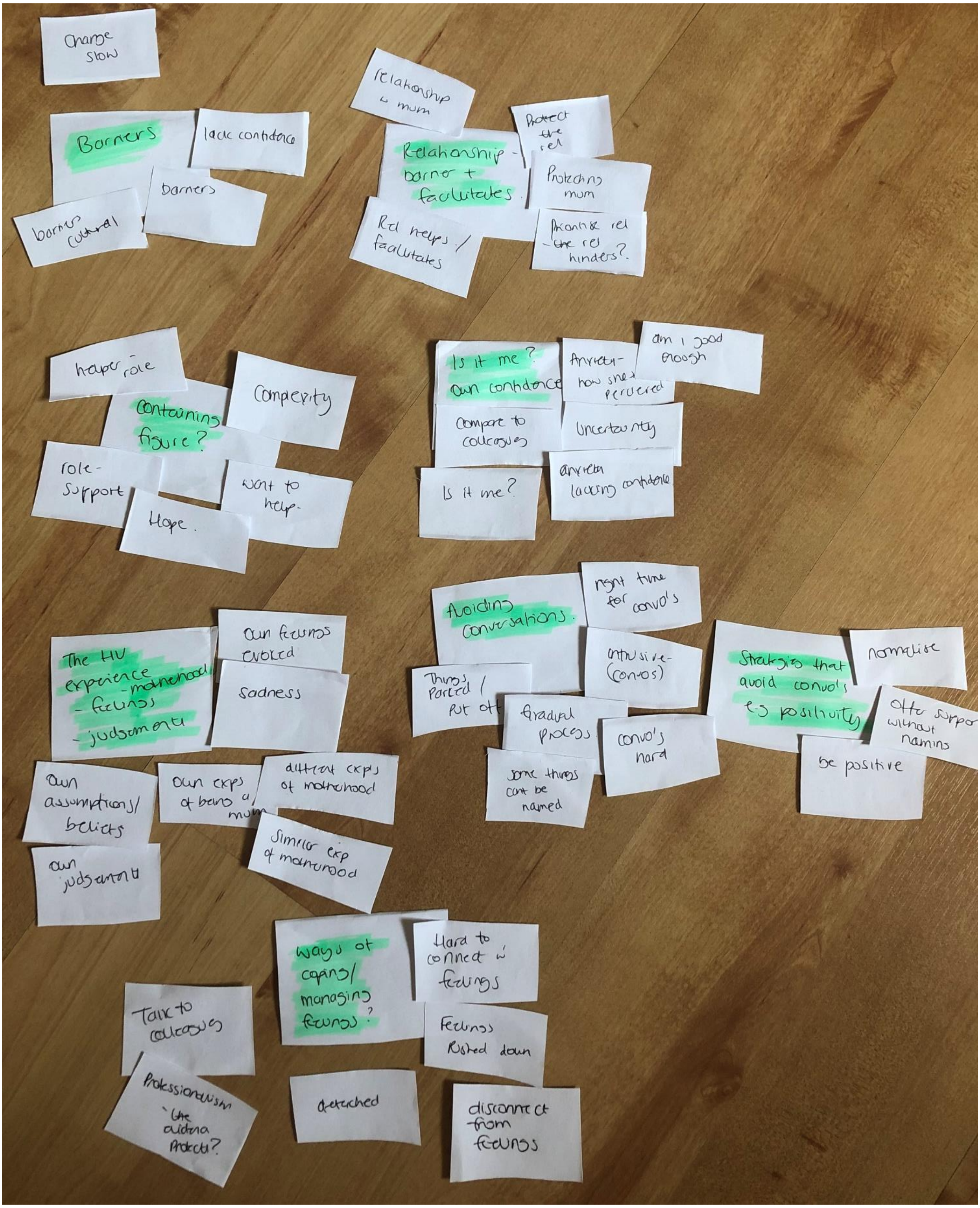
Not thinking about it- brings up difficult feelings- get pushed down	
Acknowledgement that practice may need to change **She may need to change** **Anxiety raised from thinking about this stuff?**	P28 erm (long pause) I suppose it makes me wonder if I need too work on it or put myself in their shoes (pause
Awareness of how she is perceived	P28 self-awareness of being a practitioner and how things, questions may be perceived,
Conscious of her impact on mums **Holding mums feelings in mind – protecting?**	P28/p29 I wouldn't want them too feel upset or make their feelings worse around their ability to parent
Anxiety/own feelings leads to avoidance	P29 that's probably why I feel a bit reserved sometimes…
Protecting the relationship	P29 want them to continue to work with us so I don't want to damage that relationship
Protecting mums feelings	P29 I suppose and I don't want her to feel like shes being judged or that we don't think shes doing a good job
Own experiences evoked- this impacts what she does **Own experiences hinder/get in the way**	P29/30 because I suppose.. reflecting on my own experiences of being a mum you can feel judged and you can feel quite erm…be really really hard on yourself and wanting to do the right thing P30 yeah …yeah so maybe if I hadn't experienced feelings or whatever myself I would be straight in there but also would I be you know empathetic.... probably but you know…I'm not sure

Rationalising/justifying not naming difficulties **Distancing of responsibility – whats theirs vs hers**	P31 I’m very much a sort of you know …this is your baby….empowering really, like im here to give you this information or you know erm but ultimately its your baby….do what you like, trust your instincts..that’s sort of my approach
Positivity as a way of masking difficulties?	P33 going round to listen and giving mum lots of positive affirmations of their interactions then that’s what il do
Role	P33/ 34
Trying to make sense / rationalising	P34 maybe that’s why I park things and go back and think right what does this
Rationalising / justifying **Way of switching to the process?**	P34/35 maybe that’s why I park things and go back and think right what does this mum actually need…if I send her to that peer group, postnatal group is she gona feel judged by the other mums actually, coz they are a universal group of women or is she gona be better suited and im not sure today…so il come back, will she be better suited to the infant massage group which is a bit more touchy feely and they are targeted and they are quite similar yeah or is her mood not so great today but she had a bad night last night so il come back next week and review that and you know if she is showing signs of PND then il sign post to the GP..so again its not like an immediate thing..yeah
Observing difficulties	P37 when I see that, when I see a baby that’s sort of being ...mums trying to soothe the baby but uncomfortable doing it and babies not settling, baby wants mum to be calm and settled you know when you see that ….really on edge as well and that’s why babies crying
Some things cant be said / unspoken / cant be named	P37 you can feel as a practitioner like ‘aww just calm and the babies probably going to calm’ but I can’t say that to that mum, its, its, its I suppose quite frustrating,
Difficulties feel unmanageable	P37 its not just a quick fix its because your you know, its just such a big a big thing
Protecting mum	P38 you don’t want to like I said before damage that mums feelings of worthlessness even more
Own insecurities evoked	P38 what its like, erm I suppose its like (pause) I suppose if feel a bit worthless myself, coz I’m thinking gosh I don’t know how

Lacking confidence / skill?	
Lack of confidence leads to avoidance	P39 to tell her or talk to her about it at that moment and that's probably why I do go back and reflect but actually dealing with it there and then is probably the best way, but I suppose its confidence in me maybe because of the fear of causing more damage to that relationship potentially but maybe mum wants me to notice and give some suggestions
Prioritising the relationship- hinders	P39 that's probably why I do go back and reflect but actually dealing with it there and then is probably the best way, but I suppose its confidence in me maybe because of the fear of causing more damage to that relationship potentially but maybe mum wants me to notice and give some suggestions
Am I good enough?	P39 you feel oo I could have done that differently or why didn't I say something erm yeah so that is quite difficult
Comparison to colleagues	P 40 that is massively there thing
Relationship facilitates	P40 but maybe for whatever reason id be a bit more reserved depending on our relationship, the you know lots of things
Achievement for her / reward	P42 I say successful I felt like I made a change and a difference, not a change but made a difference by supporting her
Am I doing a good job? Am I helpful	P42 maybe it's a case of me thinking we're not making a difference
Not knowing/ lacking confidence/ judgement from peers?	P46 sometimes I felt I guess more challenging erm with families where erm (pause) the sort of socioeconomic thing whatever the word is, I feel absolutely not now…. the same (socioeconomic), that's how I felt initially, erm im talking back to when I first did my training and I didn't know anything I guess its just confidence; of they know more than me or they don't trust what I'm saying coz they don't think I know what I'm doing
Own experiences of being a mum- this helps her feel more confident in her job	P47 and having a baby yourself that helps as well

Helper	P b49 HV’s we all want to help we all want to be kind
Own experiences as a mother of feeling depressed – **These conversations connect her with her own experiences**	P49 but I think there is an element of erm (pause) our own mental health within the erm profession, coz just purely coz of the nature, yeah, so yeah I think its really relevant stuff and im sort of confident to talk about that coz maybe you know in the early days of my profession I was like oh maybe all those questions I asked those mums, if id have been asking my self those questions as a midwife..i was hitting those depression

Appendix R. Individual sub/ super ordinate theme development process



Appendix S. Stage 2- Group theme development

Superordinate	Sub theme	Emergent themes	People with emergent theme	Total contributing to theme
The felt experience- connection to the personal	Powerful feelings evoked	Frustration / anger Gut feeling / instinct Anxiety Sadness Shock/ disgust	1, 3, 5, 6, 7, 9 2, 3, 4, 9, 2, 3, 4, 5, 6, 10 3, 5, 6, 8, 10 2, 5	10
	Maternal self-elicited	Shared vs not shared experience of motherhood Hidden parent self	2, 3, 6, 7, 8, 9, 10, 2, 3, 9	7
	Being the one to judge and being judged (a parallel process)	Judgements as part of the role Is it me?	1, 2, 3, 6, 7, 8, 9, 10 6, 7, 8, 9, 10	8
The impact of containing and carrying the burden	Container – a process of re-parenting the parent	Tolerating distress Working with complexity The supporter / safe base	2, 3, 4, 5, 1, 2, 3, 4, 5, 7, 8, 9, 10 1, 2, 3, 5, 6, 8, 9, 10	10
	Hopeless, helpless & powerless	The burden of not fixing Unwanted /rejected help	1, 2, 3, 4, 5, 6, 7 1, 2, 3, 7,	7
	Left to carry it	I'm responsible Unsupported Carry it/ take it home	1, 2, 6, 7, 9 4, 2, 3, 4, 7,	7

		Full up/ overwhelmed	4,	
How to name the elephant in the room	Re-framing	Have to be positive Normalising	5, 7, 8, 9, 10 4, 10	6
	It's not the right time	Now's not the time Don't say it straight away	1, 2, 4, 7, 8, 10, 1, 2, 8,	6
	Walking on eggshells	It's the way you say it Chip away/build up Tread carefully	3, 4, 6, 8, 1, 2, 3, 4, 9 7, 9, 10,	9
Coping mechanisms	Protecting the self	Humour Disconnect with feelings Feelings denied / blocked/ cut off Guarded	3, 4, 8, 2,4, 5, 9, 2, 3, 4, 7, 8, 10 3, 5,	8
	Professionalism-the safety in knowing and having a solution	Solution focused 'Knowing' Switch to the process	1, 2, 4, 9, 10 4, 10 2, 3, 8	7
	Sharing the burden	With colleagues Support from family	2, 5, 8, 10, 7, 8,	5
Some things help, some things hinder	Relationship both facilitates yet blocks	Relationship provides safety A pull to protect (relationship blocks)	1, 3, 4 5, 7, 8, 9, 10 3, 4, 8, 9, 10,	8
	When they don't see what you see	Parents insight facilitates Lack of insight hinders	1, 2, 4, 5, 6, 9, 1, 2, 4, 5, 8,	7

	A lack of time, training and confidence	Lack of time training confidence skill and experience helps	1,2, 3, 4, 5, 8, 1, 4, 8, 3, 4, 8, 9, 10 3, 4, 5, 6, 8, 9, 10	9

Appendix T. Table with finale superordinate themes and sub themes with quotes from multiple participants

Superordinate theme	Sub theme	Example quotations
The felt experience- connection to the personal	Powerful feelings evoked	**HV 2 I felt sick to be honest with you because I couldn't say anything negative to her I had to turn it around and somehow put her in his shoes but the thought of a 3 year old little boy wanting his mammy to go upstairs and give him a kiss night night and tell her she loved him and** she wouldn't HV 3 I have to really sort of be aware of my own sort of feelings when I go into that house. Then having been thrown out of the house and actually feeling, I was quite frightened **HV 4 sometimes you just have a feeling something's not quite right** **HV 5 And that mother, what she said about her child could be really shocking. It would go into your stomach, she could say really cruel things and that was hard to hear…….** **HV 6 I mean really it's a sad feeling, I feel sad for them yeah concerned for them, feel sad and concerned** **HV 8 Aww, it feels really sad because there's a lovely baby there in the room. And you can see, it's not just about what she's saying, it's about what you see** **HV 9 But you know when you've got that niggly feeling? That instinct, that kind of gut instinct** HV 9 It does feel difficult, it really can be difficult, HV 9 I suppose kind of emotion-wise, it makes you feel like this child is precious, and why are you not doing your utmost to protect it?................I think that's how it feels. Actually, there's hundreds of thousands of people out there that are desperate to have children, and it kind of makes you feel like, "You're privileged, you've been given this absolute privileged opportunity." 'Cause that's how I see mine, being a parent, and you say, "Well, why wouldn't you do your utmost to protect that privilege you've been given? **HV 10 Feels really sad, feel quite sad for her**

	Maternal self-elicited	**HV 2 as a person I just can’t understand it as a person me you know I’m one of 3 and I’ve got 2 children and I’ve never experienced anything, like that and as a health visitor thank god it’s not common** HV 3 I’m always aware of my own bias of how I brought up my children……is always going to have some influence **HV 3 Yes, of course it does, because you sit sometimes, you always sit in the room and you’ll remember, “Oh yes, when I had, mum of two and a baby, I remember what that was like.” So that is, but it can also bring back negative things as well. I can remember with my own children, how stressed I was about feeding, when I was spoon-feeding them when they were little. And particularly my youngest one was really difficult** **HV 6 you know I’ve got 3 of my own children and I absolutely love having my babies, I loved every minute of it ..I was very very lucky you know I had good pregnancies and good deliveries and everything went well so I think I was very ignorant, probably in my own little bubble so when I first started HV I didn’t fully appreciate what it feels like or how it cannot go like that or what could influence women to feel that way about their babies** HV 7 So again, I’d say it’s a hat thing. “Xxxx, you’re a health visitor at the minute, you’re not a mum. You’re not this mum, so her life is different to yours.” As a parent I think you do relate better to families, and they’ll often say to you, “Are you a parent?” And I will say, “Yeah, I’m a parent, I’ve got two children.” They’ll say, “How old are they?” Da-da-da. And I will never hold that information back, because I don’t think I would come into health visiting if I wasn’t a parent, honest. I have had quite an enriched experience with health visiting, I kind of felt like I had a pull to there HV 8 Oh, I mean as a parent myself, I know that it is hard. It’s not easy, and I think parenting, there’s no book to say how it’s done right HV 8 Especially when you’ve been through it before, you can really form these relationships with these families

		HV 9 P16 That emotional tie is, "Well, I know what it feels like to have that attachment with my baby and how important it is, and it's really important for mums to have that relationship." And it's almost guiding into, "This is how it progresses; this is what it should look like." HV 9 I mean I have children of my own, but I never say that when I'm out in practice HV 9 but obviously I instantly loved my babies when they were born, and I had that lovely relationship with them even when they were sort of not even here HV 10 sadness I suppose for me is because maybe I use my own erm experiences as a mother
	Being the one to judge and being judged (a parallel process)	**HV 1 you have to be compassionate with the client, but then you know at the same time, so that's why I try and approach in a sensitive manner asking them a bit more how they feel about it before I'm jumping to any conclusions , being open minded not judgemental , because some mums go through a lot of stuff** HV 2 P50 I do think though when you're doing this work with the parents you've got to be careful not to a portion blame……well coz of the way they were parented and they don't know any different however if there best is not good enough for that child and that child's future the child comes first and yes its difficult but our responsibility is to that innocent child and sometimes we can't get the parents to engage to make the changes HV 3 Well, because I think they can't understand how I wouldn't criticise, or particularly, "But how can you not judge?"…………….. I think if you went in with a judgemental, then you just wouldn't go back in again. And it's not about my judgement, well, it is, because you're always judging, "Is this child safe? Is this mum safe?" So you are making judgements, but you're not making criticisms So I think the judgements that I'm doing are based on (sighs), on things like safety and wellbeing **HV 6 id like go and visit these women and they'd be sat on their sofas on maternity leave in their beautiful houses with their beautiful babies…their beautiful cars on the front drive and they would just be in pieces, they'd be in bits and id be like what is going on here, what is going on…………………. and also you know the other thing I think I felt a bit mean afterwards coz I think was a bit judgmental like 'for goodness sake, how can you be feeling sad when you've got these beautiful babies**

		HV 6 I think I felt quite frustrated, I felt quite erm confused perhaps ..erm uncomfortable with my erm….I think I just felt… HV 7 I really enjoy working with families that are vulnerable, I like the challenge of hard-to-engage and sort of breaking down that wall with them. I don't enjoy working as much with families that kind of are affluent, because I think they kind of know what they're doing, and the child's needs are often very much met HV 7 You're not working, I don't understand why you can't hoover. I know you've got twins, but it's ten minutes, it's a two-bedroom flat, it's not going to take that long HV 7 why can't you just get your child dressed? It's eleven o'clock in the morning, what is stopping you? HV 7 because you have to think about how you're being perceived by them. And I think often you need that patient feedback, you don't always get it right. You need to accept that sometimes you're just not gonna be everyone's cup of tea, you don't gel sometimes. And that does upset me still now, because you're just there and you wanna do your best for that family **HV 7 Horrible, horrible. Because I thought, "She thinks I'm a really rubbish health visitor." And I know mums talk, and my name would have gone round. So my reputation within the acute sector** **HV 8 And we don't get on with everybody, do we? That's the thing, some people, the way that they perceive us, especially maybe health visitors. For some people, they might think, "Oh, they're nosey, they're coming round asking questions** HV 8 and **sometimes I think your own judgement can go in there, and we've all got these pre-judgements, haven't we**? HV 8 Because sometimes people don't know, they think health visitors come in to make sure their house is clean, they come in to snoop around, they come in to ask lots of questions HV 9 **and as much as you want to be non-judgmental, and very open there was things coming up**

		HV 9 but didn't look like a mum of, this was baby number eight. So did not look like an experienced mother (sighs). Well, we shouldn't call it experienced, what is experience? But a mother who's had other children who have also bottle-fed HV 9 Yeah, I mean that can be difficult, because if the first time you've met them it's a social care, safeguarding case conference … HV 9 or a health visitor came round," and they sometimes have quite negative views HV 9 And I hope I am non-judgmental, and I very much want to be an advocate for my vulnerable families HV 10 I think I probably felt, without judging her I probably felt does she know how to interact with what her needs are now she's 6 months old **HV 10 maybe you ask yourself is it because I'm here and that's how there feeling and maybe our relationship she would get more from a different …sometimes it might be personalities………… oh how the HV's coming round does the HV think I've got a problem'** HV 6 and I think there gona look at me a different way aren't they HV 7 I felt like people liked nurses and it's very positive, they trust you, they come to you, they confide in you. The transition to health visitor wasn't the same, people are like, "Well, you work with Social Services."
The impact of containing and carrying the burden	The container and a process of re-parenting the parent	HV 2 helping to support the mum coz it might just be a little glitch in their relationship or it might be something major **HV 1 coz I don't want them to feel as though they are left out and no body to turn too in times of need** **HV 3 There's probably a little bit of a maternal part of me that comes out, about creating an atmosphere in the room that feels gentle and safer** HV 3 So that maternal bit is about maybe, "Let's see if I can help you to make it better."

		HV 4 I'd literally have fifteen minutes of her just crying and telling me over and over again about how her partner used to rape her, and all this kind of stuff. Really horrible, horrible circumstances and then I'd get other calls from her saying, "You're not helping me," and then hanging up on the phone and then not answering me for months at a time. So it was very tricky to deal with HV 5 Because the adult's needs are so powerful I suppose, and so complicated. And these are abused children, these parents are abused children, so there's no adult or parental part you can connect with. Do you see what I mean? **HV 5 I think sometimes with me she could manage it a little bit better, because I was there, I suppose, I could talk it through…… But we tried to calm the situation together, and me talking through and calming her so she could perhaps calm her child** **HV 5 families we see (voice breaking), they're so complicated and so complex that sometimes that relationship between a child and the parent gets completely overlooked in a way, because of all the other problems. Like mother's health, or domestic violence……… not actually the relationship between the mother and child**, HV 5 I mean that it was like she was throwing it at me **HV 6 it's not easy it's not easy…all you can do is draw on those skills and keep trying to role model…there's lots of theories isn't there that if we role model that sort of warmth and empathy and containment that the parents will …like there's some little thing inside the parents brain which will think oh somebody's thinking about my feelings oh somebody is thinking about my babies feelings and just maybe tune them in with it a little bit it's not something that you can say to somebody necessarily it's something that you can..it's much more subtle than that…** HV 6 often the parent wants to offload a whole load of stuff on to you of their own about their own difficulties and their own challenges……. sometimes there quite over whelmed with their own agenda and they're not always tuned into their baby's agenda

		HV 7 I came in with the focus of working with the families that were hard-to-reach, or had not been parented as we would have been, appropriately, and so their cycle's repeating itself, and it's about breaking that cycle HV 7 And at times you thought, it's just chaotic and it's beyond belief at times. Like where do you start? HV 8 You might be talking to a client who has never had a healthy relationship ever in their life HV 8 And it's trying to get them to think about the child's feelings, rather than what's going on for them. And a lot of the time, the families that we visit, there's a lot going on for them. HV 8 because you might be the only person that's giving them any positivity ever in their life. You may be the only person that's saying, "You're doing a really good job here. You don't have to get it right every time, it's only a third of the time, and parenting's not about getting it right every time, it's about doing our best." So you may have been the only person that's ever said that to them HV 8 But I guess with regards to relationships, it's hard because for some families, and for some mums, they may have never had it their self. So it's about teaching them that this is how you can do it a better way, or support them in changes for their babies, and it don't carry on in the babies like it has done for them **HV 8 And you're that nurturing person that's giving them all this advice where it could have been their mum that would have given that advice** HV 9 I see myself as that advocate for that family, to encourage and to nurture and to support them through it really. And that's that emotional I think HV 9 Does it matter if it's a safeguarding family? Yeah, cause that's the one that springs to mind HV 10 HV's we all want to help we all want to be kind
	Hopeless, helpless & powerless	HV 1 yeah so I mean I like to try and sort of say at least I've tried my best but then sometimes feels like banging your head against the wall , I don't know if that's the right expression, it's a bit dramatic err but yeah it can be feel a bit hopeless or helpless may be a better word you feel like you want to help but they don't want the help

		HV 1 it’s a bit dramatic err but yeah it can be feel a bit hopeless or helpless may be a better word you feel like you want to help but they don’t want the help HV 2 there’s a lot of negativity, it doesn’t matter what I say to her ..and this has been going on for 4 years..it doesn’t matter what I say to her **HV 3 I’ll help you if you want me to, if you don’t want me to help you, that’s quite difficult.” Because where are we gonna go with that** P18 Well, if you want help I’m here.” But just keep giving that offer HV 3 Well no, so often when you’re nurse-trained you want to offer a solution, you want to make it better, and sometimes that’s not right. That cannot be immediate HV 4 And there’s lots of problems, but there’s also lots of problems where there’s no answer to them HV 5 Oh, that was really difficult, because I felt that I couldn’t help her, What was happening for this little boy to become so distressed, and so aggressive, and so disturbed HV 5 That I couldn’t manage the situation, and there was more going on that I needed help with……… I suppose you don’t know what to do. So there’s a moment there where you feel, you don’t know what to do HV 6 P17 I’m a right old nurse I just wana fix it, make it better make everyone feel better again **HV 7 So it’s hard, and you can wake up in the middle of the night. I’ve had panic attacks from them, because you feel quite powerless and helpless.** HV 7 That can be challenging at times because they don’t really see the benefit of a health visiting service

		HV 7 Overcoming several barriers, it's really hard at times just to streamline it back to the child, because you get so caught up in all their issues. And to be honest they are issues, and to unravel them, it's like layers of onion peeling because you can't get to the core
	Left to carry it	HV 2 well you're a professional and your moral responsibility is too families that you're working with in the community you canne go out see a problem and walk away you really shouldn't be in the job should you **HV 2 coz you do, sometimes go home and your sitting watching the tele and think that poor little boy** **HV 3 she might be a child that I'll take home** **HV 4 but then I'm left with it. Until actually it's severe enough it will go to the perinatal mental health team, but their timeframes are longer than actually things like talking therapies sometimes** **HV 4 we're just carrying other people's problems with us all the time** HV 6 I get quite frustrated that I have nowhere to send them on to, I feel like xxxxx really lacks infant mental health services and awareness, if I was working in xxxx and had identified this difficulty I could refer them they have one of those pip and in xxxx they have parent infant service you can refer to them to see a specialist psychologist and in xxxx they have some links with xxxxx parent infant psychotherapist, but we don't have any of that in xxxx, I think in xxxx there's a certain amount of frustration that there isn't more support from another layer HV 7 But yeah, I wasn't supported, and I felt really deflated, and it came across as I just failed for that child, and that's horrible, a horrible feeling, and I will just carry that with me **HV 7 You carry them for a long time, whether you're working with them or not** HV 7 And I thought, "I need to act on this now. This is worrying me."
How to name the Elephant in the room	Reframing	HV 2 I couldn't say anything negative to her I had to turn it around

		HV 10 I'd also erm you know have open conversations about it being difficult with a baby and that you know it takes time to get to know your baby, that kind of thing HV 10 going round to listen and giving mum lots of positive affirmations of their interactions then that's what I'll do HV 10 think I was like 'oh look she's so happy with you, she is such a smiley happy baby wow' erm it was a bit more like that not so direct **HV 9 And I remember sort of saying to her, "Oh, you're doing great, look at her, she's watching you and she's wanting you to interact with her. Look, she's trying to smile at you or she's trying to coo at you." And then she was saying, "Oh yeah, she is, isn't she?"** HV 7 Look, he's really interacting there. If we limit screen time and do some blowing bubbles, he's loving it," because the nursery nurse was doing blowing bubbles. "He's moving his car round the train track, that's really positive, he's giving me eye contact, he's pointing. These are all really positive." HV 8 So for them, and for them to hear it, even if it is challenging, even if you have to say something challenging, you can still say something positive. **HV 7 but yeah, they definitely need, you need to draw on a positive. It's a bit like, I'd say the sandwich effect…. So when you have two positives to one negative** HV 4 do quite often when I'm talking and seeing how they're feeling, just kind of put maybe a bit of a caveat in there about why we're asking, and just kind of explaining what we know, that if you're not feeling well a) you're not feeling well and that's not good for you, but also if you're feeling a bit flat or a bit tired and therefore it's difficult to smile at your child, then your child isn't gonna smile back in the way, and that kind of serve-and-return relationship HV 5 "Actually, this is a hard job and despite everything you're doing well."

	Its not the right time	**HV 1 so erm, I think I would probably have too erm in these cases if they don't disclose but I am seeing something , I'm not necessarily going to say straight away that I think you have a bonding problem or something like that because u know I can see that .. I definitely wouldn't do that but then I would try and go back quite soon after………, so yeah just asking these questions and going back a few times maybe if you feel like there is something emerging but you're not sure about it** **HV2 the clinic setting is a drop-in clinic it's not a place to do any in depth work around parenting or assessing the parent infant interaction……. so it's not appropriate to to do it in a clinic ..that isn't the setting** HV 2 you would go back again, if you went and say you'd gone out to do a routine visit and the mother was really upset crying it could be about anything ..coz there's been a death in the family or her moods low or you know she's got debt problems but your looking and your thinking there's no interaction going on amongst her and this baby, she's completely ignoring this baby you wouldn't do anything about it in that situation you'd go back because you couldn't make a view like that and certainly not discussing it with mother after an observation, that would be grossly unfair **HV 4 now's not the time to go too far into this**." HV 4 That's not something I'm going to say in a ten-minute clinic, because that would have to be framed in a very particular way to get her attention in the right way without putting a barrier up again HV 7 And that's what I mean, it's like a drip feed. So, it's about going back in again and again and doing listening visits with her, to hear her story and let her talk **HV 10 erm yeah and I suppose its..its parked a little bit and I'll be you know if I observe something maybe not in that contact I will then sort of go back and talk about relationships maybe …maybe another time erm** HV **8 So in the moment it's thinking, "Right, I'm gonna address this but I need to pick the right moment to address it."**

		HV 8 Because as health professionals, a lot of our role is very much layering. So I might say a little bit today, and then I'm gonna come back next week and I'm gonna build on that information
	Walking on eggshells	HV 1 but yeah I would try and approach the subject, I would yeah, try to either go around it or approach it HV 2 coz you have to build up these things **HV 3 Right, I'll be careful about what I say. How am I phrasing that**? HV 3 Well, it's just like anything, you think about how it's phrased isn't it? HV 3 So it might be just doing some of those gentle things about getting them to notice what's going on with their child, to help that connection….. But I think it's just being really gentle and sensitive, but not disregarding it. HV 4 I think it's then just quite slowly, slowly approach HV 4 and I think it is about how you phrase it. HV 4 And I think it's the same with the parent and infant relationship services, it's about how you frame what you're seeing HV 6 because I think you have to find the way to point it out to them without…quite often when people don't have that insight they are much more defensive to work with and are much more you know there quite sensitive to anything that they could interpret as criticism ..so you have to choose your words very carefully HV 6 so I think there quite sensitive to criticism, so you just choose your words carefully **HV 6 so I think you don't always talk about the relationship the relationship is a bit like the elephant in the room …I mean id never say im concerned about the relationship you have with your baby** **HV 7 You tread carefully, I would say you're walking on eggshells, because you kind of, you can go in with an agenda or a script, "I think I'm gonna do this."**

		HV 10 you can feel as a practitioner like ‘aww just calm and the babies probably going to calm’ but I can’t say that to that mum, its, its, its I suppose quite frustrating **HV 9 Because I think we have to tread a little bit more carefully** I perhaps wouldn’t jump straight into it, I would address it but perhaps not straight off, I would observe HV 8 I mean, don’t get me wrong, it can be the way that you word things, you have to make sure that you’re not upsetting anybody
Coping mechanisms	Protecting the self	**HV 2 well I don’t live with it, it’s not about what it’s like for me I don’t think what’s that like for me……… it’s not about what it’s like for me, that would be wrong for me to sit here and think what that’s like for me because that’s not what my role is** **HV 3 That gives you a bit of a ‘ouch’ sort of (laughs). Again you think, “This poor child.”** HV 3 So going back into that, so I’m actually quite defensive, I’m quite guarded………. It means that there’s not a lot of work going HV 3 So you’ve got to actually almost physically take yourself out of that and put yourself somewhere else…. HV 4 Sorry, I don’t often think about how I feel about something, obviously, ‘cause I can’t answer these questions HV 4 erm I don’t know if I had any feelings either way..i must have had some feelings I don’t remember feeling out of sorts or uncomfortable erm I’m just trying to work out what’s was going I guess ..I genuinely don’t know what my feelings were **HV 4 And then you’re not focused because you’re kind of half feeling the way you’re feeling and having to block those feelings**

		HV 4 think it's just to some extent I've detached…….. I don't think my emotional responses are what they used to be HV 4 But by the time I actually got to clinic, I could turn it on and be normal because I had to be HV 4 you haven't caught me at the best time in my health visiting career (laughs) HV 5 Because you have to protect yourself, and I think when you become aware of a whole different way of working, I have become aware that you can take on too much of the family…….. So I've become more boundaried HV 7 don't know. I've accessed counselling before, so I've talked about it with counselling. But I do reflective accounts for my portfolio, so I've done reflection in there. I suppose I just have to try and park it, HV 7 So you detach yourself, and I feel like you have two different hats sometimes. You think, "It's alright, she's just having a bad day." HV 8 I've never been told to get out (laughter) or anything like that, so generally it's okay and I feel okay. **HV 8 Absolutely, but I always think it's not about me, I will deal with me later. It's just about this mum or this child, and trying to deal with that later on if I have to**. HV 8 I think there and then, nothing personally. 'Cause when I'm actually in a visit and I'm doing that, I try to ignore. Because I think I've got to stay in the professional mode
	Professionalism-the safety of knowing and having the solution	HV 1ahh yeah if there isn't , it's very frustrating , I mean I'm always on the look out for any new charities that pop up , it's good to be in a network coz some mums HV 2 I'm looking at both of these children are acting like this do I think we need to get services in for example do we need SALT education psychology, do I think this is something pathological, do I think these children have a behavioural issue, do I think these children have autism which is what she thinks or do I think its environmental do I think its an attachment issue that's what I've got to look at

		HV 3 That's really, ooh, that really….And sometimes, again as a family nurse we'd get that a lot with young people. **HV 4 When I've kind of got answers, then I think I feel okay about what I say** **HV 9 I'm very solution focused, so I think if I'm faced with a barrier, I look at ways of breaking it down.** HV 8 Ah yeah, it can be really, really sad. But the good thing about that is I've been able to work with that family quite a lot **HV 10 I sort of adapt it slightly and will quite confidently explain to them about brain development you know obviously it's what the evidence says**
	Sharing the burden	HV 2 we do have clinical supervision and that's ideal to talk through things like this **HV 5 It's very easy to get completely taken in by a client's distress, and it's knowing how you deal with it, isn't it? You have to go and talk to other people about that** HV 7 , I mean I've spoke to my husband, just peer support HV 8 But maybe next visit you can come away, you can get some supervision from your colleagues, and then you might find that you have to do it a different way or say something a different way, or take somebody else with you to try and support you. **HV 8 I'm lucky enough to go home to a wonderful family, and they can be supportive. Equally when you're a nurse and you have a really bad day, you go home and cry to your partner**. HV 10 erm I suppose I talk to colleagues and say I've got this mum and this happened and I suppose my colleagues, some are really..that is massively there thing and they'll be like oh why don't you say this or you know so..I'm quite open about asking for that support

Some things help Some things hinder	Relationship both facilitates yet blocks	**HV 3 But I don't think, without that relationship, it's very difficult. You need to form some relationship before you can then do very much** HV 3 If you're gonna go into really sensitive things, you've got to have that sort of relationship. That doesn't necessarily mean that it's got to be a nice, cosy relationship………… So you'd have ups and downs, you'd have challenges, you'd have times where she'd say, "I'm not doing this anymore." "Okay, I'm gonna keep coming back, and that's alright." You work through that, like you're working through a relationship, and then you can challenge things HV 3 And I think that can be thinking about what the response might be. Thinking about maybe the vulnerability of that person HV 5 So it means that you've got a constant, it means that you can perhaps have more difficult conversations with them **HV 5 P6 It does depend on your relationship with the family. I mean, you have to be professional at all times and be aware that those difficult conversations can make it hard with families that you don't particularly know well. But those that you do know well, it makes it easier because you have a historic relationship with them** HV 5 P6 So you can perhaps challenge their behaviour, I suppose. HV 7 You have to accept sometimes that if the relationship's not there, you can't carry on working with that family, 'cause it's just not conducive to the child's needs, too many barriers in the way HV 8 Well, I think for me, because I've built up that relationship antenatally it's really helpful HV 8P20 I feel like I can, because by that time we've built up a therapeutic relationship with our clients. HV 8P20 I find that a lot of the time I've got a good enough relationship, and I feel I'm able to say things to families that I'm observing

		HV **8 Well you don’t want to say it, you don’t want to say it, because it’s like you’re telling her what to do. So it can be really difficult, because you don’t want to be the one that’s saying that, because you don’t want to undermine her, but you know that the baby’s really struggling** HV 8 P23 So it’s trying to make good therapeutic relationships with the family, so that then you can try and encourage them to have good relationships with their children. HV 8P23 : So I guess if you have not got a therapeutic relationship it’s extremely difficult, because you wouldn’t be able to have the challenging conversations that we have to have HV 8 P55 I think for me, I think if you can build the relationship up with Mum first before the baby’s even here, I think you’re already there HV 8 So sometimes I wouldn’t always challenge it at the first visit, because like any relationship you don’t want to go in all guns blazing like, “This is what I’m seeing.” **HV 10 i want them to continue to work with us so I don’t want them to continue to work with us so I don’t want to damage that relationship** HV 10 I suppose and I don’t want her to feel like she’s being judged or that we don’t think she’s doing a good job HV 10 I wouldn’t want them to feel upset or make their feelings worse around their ability to parent HV 10 P22 so for me explaining to mum about the importance of their relationship which I did but obviously I don’t want her having pangs of guilt about it..its tricky erm and I suppose the other thing… HV 10 P38 you don’t want to like I said before damage that mums feelings of worthlessness even more
	When they don’t see what you see	HV 1 sometimes I would assume that they don’t have the ability to reflect on it or they don’t know the baby, I think sometimes quite simply they don’t seem to understand their own babies and their needs maybe , doesn’t always come natural , maybe there not educated..i don’t mean like education but maybe they didn’t have role modelling like no other babies in the family

		HV 1 if you ask the questions and you go back again and there not picking up on..there's something really ..they can't seem to realise that there's a problem , yeah that can be quite tough, coz then ermm HV 2 well you broach it as sensitively as you can ..it's much easier if the mother has identified something but usually it's us **HV 4 Yeah, and I think that she was very open from the beginning as well. I think it's more complicated when they can't see it.** HV 5 there's a mum who was very open about talking about how she felt nothing for her child………… And we could talk about that……. So we were able to have the conversation about why that might be, and we thought a little bit about her pregnancy, because she discovered very late that she was pregnant. HV 5 whether they've got the capacity to understand that that may relate to the way that child is feeling HV 6 you know has a really good insight into her emotional wellbeing and mental health…she is quite upset that she sometimes feels these negative feelings towards her babies **HV 6 I think there's both so you will get the parents that you work with who have really good insight that somethings wrong and they will tell you about they will recognise themselves that something is wrong and then you will work with parents who don't even see that its wrong they just…they just think that's how it is…so that's harder almost when you're working with parents who for instance will call their child the devil child and not don't even seem to enter their heads that that's probably not a very good thing to think about your baby or describe your baby so that's harder** HV 5 P26 Well, you've got their relationship, and her lack of capacity to really understand how affected this little boy is HV 5 P29 Yeah, so that is really sad, because the parents have no capacity at all to understand P40 And she was very articulate, she was able to say that she felt robbed of her freedom, and she hadn't been ready. So she resented her baby a little bit, so she was able to talk about that

		HV 5 P60 But some people have so much capacity to suddenly – and you can see it click – they can suddenly understand, "Of course that's what's happening." **HV 8 but it can be really hard when they don't see, you know, they don't see what you see** **HV 9 Yeah, no, it was easier because actually she had quite good self-awareness I think, so it was easier to kind of think, when I talked her through it she was like, "Yeah, that's exactly what's going on, now I can see why my baby's behaving in this way." Not blaming herself, and not putting any blame on any one person, but actually looking at the way she was behaving and the impact it's having on** baby
	A lack of time, training and confidence	**HV 1 I duno whether we need a bit more training** HV 1 you know we don't always have enough time or we can't go back so many times that's why we refer to other services HV 3 What there isn't, is there isn't time necessarily to follow things through **HV 3 And just knowing when to back off. But then having I suppose the confidence as a professional to pick it up again, and not just think, "Oh well."** **HV 4 it's not an area I feel massively confident in……. when I'm kind of a little bit at sea I don't feel erm massively confident and I think erm its ..it was more I genuinely didn't know what was going on** **HV 4 but I've never received any training on how I'm meant to actually work with them. So it does feel uncomfortable, because you're just kind of relying on your own common sense and your own kind of** HV 5 I just felt that there was no way that I had the time or skill to be able to unpick that, and that Mum's frame of mind, HV 5 it would take a lot of time for me also to build up the trust to be able to take that forward

		HV 10 what it's like, erm I suppose it's like (pause) I suppose if feel a bit worthless myself, coz I'm thinking gosh I don't know how to tell her or talk to her about it at that moment and that's probably why I do go back and reflect but actually dealing with it there and then is probably the best way, but I suppose its confidence in me maybe because of the fear of causing more damage to that relationship potentially but maybe mum wants me to notice and give some suggestions HV 8 I think sometimes it makes me think, "Oh gosh, I hope I managed that okay, I hope I've done everything right." **HV 8 And it really, really helped. And obviously I had loads of training, the Watch, Wait and Wonder training I did, Understanding Your Baby, Your Baby's Brain** HV 8 And I guess sometimes it makes me feel like you want to stay there longer, 'cause as health visitors you don't always get long.

Appendix U. End of study notification to HRA l

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Appendix V. End of study letter to Salomons Ethics Panel and HRA

Dear (Chair of Ethics Committee),

Study title: How do health visitors make sense of talking about difficulties with the parent-infant relationship? An Interpretative Phenomenological Analysis

I am writing to inform you that the above research project is now complete, and a thesis has been written for submission in partial fulfilment of the degree of Doctor of Clinical Psychology at Canterbury Christ Church University. I have included a brief summary for your information.

Considerable evidence now highlights the role that early experiences play in healthy child and adult development (Phillips & Shonkoff, 2002). Early interactions are essential in creating 'pathways' for later life (Shore, 1997) and the parent-infant relationship is suggested to be one of the most important factors in the development of a child's brain (Winston & Chicot, 2016). Good parenting and the development of a secure bond is therefore vital for children to be able to thrive (Moullin Waldfogel & Washbrook, 2014) as well as ensuring optimal infant mental health (Bowlby, 1997).

Health visitors provide support to parents and children of pre-school age in the United Kingdom (UK) (Hewitt et al., 1989) and lead on the Healthy Child Programme (HCP) which aims to ensure the wellbeing of infants and children by providing early intervention (DH, 2009). Whilst the process of diagnosing attachment disorders may lie with clinical psychologists (Howe, 1999), health visitors can offer helpful insights into the developing relationship.

Although specific tools are available for the assessment of the parent-infant relationship (Lotzin et al., 2015), these are not utilised by health visitors (Appleton et al., 2013) and even when tools are available, they may not be used (Pettit, 2008). Having conversations about the parent-infant relationship may prove difficult amongst health professionals (Bailey, 2009). When conversations are deemed difficult, clinicians are more likely to avoid or postpone having them (Christakis & Iwashyna, 1998). Given that attachments between parents and infants are established by seven or eight months (Iwaniec & Sneddon, 2001) it is important that difficulties are spoken about early on in order that interventions can be offered.

Due to the lack of research in relation to health visitors' experiences of talking about difficulties with the parent-infant relationship, this study was felt to be important in addressing a unique gap. This study will hope to understand health visitors lived experience of talking about difficulties with the parent-infant relationship as well as how they see their role when difficulties are identified. This research provides an opportunity to understand the facilitators and barriers when having these types of conversations as well highlighting what support may be needed for health visitors.

Aims of research

To gain an in depth understanding of health visitors experience of talking about difficulties with the parent-infant relationship

Research questions

a. How do health visitors talk about difficulties with the parent-infant relationship?
b. How do health visitors make sense of how they talk with parents about difficulties with the parent-infant relationship?
c. Gain an in depth understanding of any facilitators, concerns or challenges in talking about these difficulties
d. Understand how health visitors make sense of their role in relation to these difficulties

Semi-structured interviews were carried out with ten qualified health visitors. Data were analysed using Interpretative Phenomenological Analysis (IPA) which is concerned with understanding how people make sense of their experiences (Smith, Flowers & Larkin, 2009). The analysis process yielded five superordinate themes and fifteen sub themes. The main themes were as follows; the felt experience- connection to the personal; the psychological burden; avoiding the elephant in the room; coping mechanisms and some things help, some things hinder. Table 1 provides a description of themes and participants quotes.

Table 1. Themes with illustrative quotes

Table 2

Themes and illustrative quotes

Superordinate theme	**Sub theme**	**Quote**	**People contributing to sub theme**
The felt experience-connection to the personal	Powerful feelings evoked	*I have to really sort of be aware of my own sort of feelings when I go into that house. Then having been thrown out of the house and actually feeling, I was quite frightened (HV 3)*	10
	Maternal self-elicited	*Oh, I mean as a parent myself, I know that it is hard. It's not easy, and I think parenting, there's no book to say how it's done right (HV 8)*	7
	Being the one to judge and being judged (a parallel process)	*Well, because I think they can't understand how I wouldn't criticise, or particularly, "But how can you not judge?" (pause) I think if you went in with a judgemental, then you just wouldn't go back in again. And it's not about my judgement, well, it is, because you're always judging, "Is this child safe? Is this mum safe?" So you are making judgements, but you're not making criticisms So I think the judgements that I'm doing are based on (sighs), on things like safety and wellbeing (HV 3)* *Because sometimes people don't know, they think health visitors come in to make sure their house is clean, they come in to snoop around, they come in to ask lots of questions (HV 8)*	8
Psychological burden	The container – a process of re-parenting the parent	*Because the adult's needs are so powerful I suppose, and so complicated. And these are abused children, these parents are abused children, so there's no adult or parental part you can connect with. Do you see what I mean? (HV 5)* *But I guess with regards to relationships, it's hard because for some families, and for some mums, they may have never had it their self. So it's about teaching them that this is how you can do it a better way, or support them in changes for their babies, and it don't carry on in the babies like it has done for them (HV 8)*	10

	Hopeless, helpless and powerless	*Yeah so I mean I like to try and sort of say at least I've tried my best but then sometimes feels like banging your head against the wall , I don't know if that's the right expression, it's a bit dramatic err but yeah it can be feel a bit hopeless or helpless may be a better word you feel like you want to help but they don't want the help (HV 1)*	7
	Left to carry it	*But yeah, I wasn't supported, and I felt really deflated, and it came across as I just failed for that child, and that's horrible, a horrible feeling, and I will just carry that with me (HV 7)*	7
Avoiding the elephant in the room	Reframing	*So for them, and for them to hear it, even if it is challenging, even if you have to say something challenging, you can still say something positive. (HV 8)*	6
	It's not the right time	*That's not something I'm going to say in a ten-minute clinic, because that would have to be framed in a very particular way to get her attention in the right way without putting a barrier up again (HV 4)*	6
	Walking on eggshells	*Because I think you have to find the way to point it out to them without…quite often when people don't have that insight they are much more defensive to work with and are much more you know there quite sensitive to anything that they could interpret as criticism ..so you have to choose your words very carefully (HV 6)*	9
Coping mechanisms	Protecting the self	*Because you have to protect yourself, and I think when you become aware of a whole different way of working, I have become aware that you can take on too much of the family…….. So I've become more boundaried (HV 5)*	8
	Professionalism- the safety of knowing and having the solution	*I'm looking at both of these children are acting like this do I think we need to get services in for example do we need SALT education psychology, do I think this is something pathological, do I think these children have a behavioural issue, do I think these children have autism which is what she thinks or do I think its environmental do I think its an attachment issue that's what I've got to look at (HV 2)*	5
	Sharing the burden	*But maybe next visit you can come away, you can get some supervision from your colleagues, and then you might find that you have to do it a different way or say something a different way, or take somebody else with you to try and support you. (HV 8)*	5

Some things help Some things hinder	Relationship both facilitates yet blocks	*So for me explaining to mum about the importance of their relationship which I did but obviously I don't want her having pangs of guilt about it..its tricky erm and I suppose the other thing… (HV 10)*	8
	When they don't see what you see	*If you ask the questions and you go back again and there not picking up on..there's something really ..they can't seem to realise that there's a problem , yeah that can be quite tough, coz then ermm (HV 1)*	7
	A lack of time, training and confidence	*And I guess sometimes it makes me feel like you want to stay there longer, 'cause as health visitors you don't always get long (HV 8)*	9

The aim of this study was to explore how health visitors make sense of their experiences of talking about difficulties with the parent-infant relationship. Findings in this study, highlighted the emotional impact on participants and a range of coping mechanisms which were conceptualised as protective. Whilst participants recognised difficulties with the parent-infant relationship, there was a tendency to avoid naming difficulties. Clinical implications included health visitors being offered consultations and training and highlighted a role for psychologists within this. Future research into health visitors' experiences of working with fathers would be helpful, as participants in this study, primarily reported their experiences of working with mothers.

In relation to dissemination, I plan on submitting to the 'Journal of Infant Mental Health'. I am also planning on forwarding a summary of the findings to participants.

Kind regards

Stefanie Kouvaras

Appendix W. Research summary to be sent to participants

Study title: How do health visitors make sense of talking about difficulties with the parent-infant relationship? An Interpretative Phenomenological Analysis

Dear Participant,

I would like to thank you for agreeing to take part in the study and for giving up your valuable time. The research has now come to an end and therefore as agreed, please see below a summary of the findings.

Background

Due to the lack of research in relation to health visitors' experiences of talking about difficulties with the parent-infant relationship, this study was felt to be important in addressing a unique gap. This study will hope to understand health visitors lived experience of talking about difficulties with the parent-infant relationship. This research provides an opportunity to understand the facilitators and barriers when having these types of conversations as well highlighting what support may be needed for health visitors.

Method

Semi-structured interviews were carried out with ten qualified health visitors. Data were analysed using Interpretative Phenomenological Analysis (IPA) which is concerned with understanding how people make sense of their experiences (Smith, Flowers & Larkin, 2009).

Findings

Five master themes emerged from the data; the felt experience- connection to the personal; psychological burden; avoiding the elephant in the room; coping mechanisms and some things help, some things hinder.

The felt experience- connection to the personal

This main theme encapsulates the felt experience of participants and highlighted how participants own feelings and experiences were evoked from encountering difficulties with the parent-infant relationship. Seven participants reported that being in these situations connected them with their own experiences of motherhood. The majority of participants acknowledged how a big part of their role involved making judgements, which included judging the parent-infant relationship. Participants were aware that they held assumptions about parents and families that were important to recognise.

The psychological burden

This main theme encapsulates the emotional burden placed on participants from recognising and having conversations about the parent-infant relationship. Participants described working with high levels of complexity, which included working with families where there were concerns related to domestic violence or parental mental health. There was a sense that the parent-infant relationship was one of many concerns which may lead to it being overlooked. A number of participants used words such as hopeless and powerless to describe how it felt working with parents where there were often a range of issues including difficulties with the parent-infant relationship.

Avoiding the elephant in the room

Participants used strategies such as being positive and normalising when they noticed difficulties instead of directly naming the difficulties they were seeing. Participants often described a process of observing difficulties but needing to find the right time to talk about it, which included going back another time. Nearly all participants described a process of being careful about how they named difficulties and a sense that it had to be phrased the right way. This process was conceptualised as a way of avoiding having the conversation as there was a worry about how it would be received by parents.

Coping mechanisms

This main theme captures participants coping mechanisms for working in these difficult contexts. As a way of managing difficult feelings that were brought up, participants described a range of processes from denying their feelings to blocking them. Participants at times, appeared to find it hard to talk about difficult feelings and experiences and tended to switch to talking about the process of what they did or solutions. Participants talked about the importance of talking to colleagues or using supervision as a way of coping, as well as having support from partners or family

Some things help, some things hinder

Participants talked about the importance of having a relationship with parents in order to be able to name difficulties with the parent-infant relationship. Participants reported that parent’s capacity to see the difficulties made it easier for them to have the conversation. Alternatively, when parents lacked insight, this made it harder to be able to talk about the difficulties. Confidence was recognised as a factor that was necessary in order to be able to have conversations about the parent-infant relationship and therefore when participants didn’t feel confident, this could lead to conversations not taking place. Training was conceptualised as being helpful to participants in feeling able to have conversations about the parent-infant relationship.

Conclusions

The aim of this study was to explore how health visitors make sense of their experiences of talking about difficulties with the parent-infant relationship. Clinical implications included health visitors being offered consultations and training and highlighted a role for psychologists within this. Future research into health visitors' experiences of working with fathers would be helpful, as participants in this study, primarily reported their experiences of working with mothers.

Further dissemination

As stated in the study information that you consented to before taking part in the study, it is hoped that this research will be published in a journal. As such, anonymised quotes may be included in order to highlight key findings. If you have changed your mind in relation to this, please contact me before August 2020.

I hope these findings have been interesting to you and once again thank you for taking part.

Best wishes
Stef Kouvaras
Trainee Clinical Psychologist

Appendix X. Journal author submission guidelines

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