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ARTICLE

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Finding focus in a difficult landscape: Therapists' experiences with challenging video guidance processes for parent–infant dyads

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ABSTRACT

Marte Meo video guidance uses filmed interaction of the actual parent–infant dyad in the guidance of caregivers. Exploring the challenges that therapists meet in the guidance of parent–infant dyads may illuminate important aspects of the method itself as well as the therapists' role and requirements. This could lead to method development and improved practice, but is hitherto little addressed. In this paper, we explore how skilled therapists experience and handle challenging or failing guidance processes with parent–infant dyads. We analyzed interviews with 13 Marte Meo therapists/supervisors using team-based reflexive thematic analysis. Four main themes were identified: promoting relational growth in a coercive context, building an alliance that feels safe for the parents, looking at positive moments in difficult lives, and handling intense feelings as a therapist. Our findings show that therapists experience specific therapeutic and ethical challenges with a vulnerable subgroup of parent–infant dyads where child protective issues arise, where caregivers' insecurities impede the therapeutic relationship, and where caregivers have unsolved relational or mental health problems. The therapists' role becomes pivotal and demanding with regard to the therapeutic alliance, the therapeutic interventions in the guidance process, and their own need for regulation, supervision, and structure. Identification of these vulnerable dyads early in the process could facilitate a better adaptation and practice of video guidance. Our findings suggest a need for supporting structures, clinical supervision, and training that address these challenges.

KEYWORDS

Marte Meo, parent–infant interaction, reflexive thematic analysis, therapist perspective, video guidance

1 | INTRODUCTION

What is it like for therapists to give video interaction guidance to parents who struggle to understand and interact with their infants? What do their experiences with challenging video guidance processes tell us about the guidance of these dyads itself, and the therapists' role and requirements? In this article, we explore the challenges

that therapists encounter in Marte Meo video guidance with parent–infant dyads, and how these challenges shape the process, their use of the method, and their own role as therapists.

The quality of interaction between infant and caregiver is central for the support of development and attachment (Ainsworth, Bell, & Stayton, 1974; Meins, 2013; Van IJzendoorn, 2004), and disturbances in the parent–infant relationship are a risk factor for child mental health problems (Lyons-Ruth et al., 2017; Rask, Ornbol, Olsen, Fink, & Skovgaard, 2013; von Klitzing, Döhnert, Kroll, & Grube, 2015). About 9% of infants live within clinically disturbed parent–infant relationships (Skovgaard et al., 2007), which have been linked to both negative expectations from the parents as well as deviant handling and reactions to the child. Parent–infant interaction and the parent–infant relationship are therefore the focus of a range of guidance and treatment approaches (Barlow, Bennett, Midgley, Larkin, & Wei, 2015; Wright & Edginton, 2016). Guiding the caregiver to reflect on the interaction can take place while the interaction is unfolding (Cohen, Lojkasek, & Muir, 2006; Sadler et al., 2013), through the use of video material from the interaction (Fukkink, 2008; Powell, Cooper, Hoffman, & Marvin, 2013), or both (Bernard et al., 2012; Doesum, Riksen-Walraven, Hosman, & Hoefnagels, 2008).

Video guidance uses filmed everyday interaction of the actual dyad in the guidance of parents, often during home visits. Its effect and function have been widely documented (Balldin, Fisher, & Wirtberg, 2016) and to some extent conceptualized, especially for parent–child dyads (Hedenbro & Wirtberg, 2012; Steele et al., 2015). Several distinct methods have been developed, among them Marte Meo and its manualized variant called video feedback of parent–infant interaction (VIPI) (Onsoien, Drugli, & Hansen, 2015). Marte Meo is used in four continents, and more widely implemented in several European countries as well as Australia, and improves parent–infant interaction, parental sensitivity, and infant development also in more vulnerable dyads (Gill, Thorød, & Vik, 2019; Høivik et al., 2015; Kristensen, Simonsen, Trillingsgaard, & Kronborg, 2017). It originated out of an intersubjective perspective and, like video-interaction guidance (VIG) (Kennedy, Landor, & Todd, 2011), has a decidedly solution-focused stance, omitting material that shows negative or ineffectual interaction. This stance has been cited as a key difference to many other methods (Landor & Ljungquist, 2018) and conceptually linked to resource-orientedness (Bunder, 2011; Kiamanesh, Olafsen, & Drozd, 2018), salutogenesis and family resilience (Hedenbro & Wirtberg, 2012). Marte Meo has also been related to Stern's developmental model, and mentalization (Vik & Hafting, 2009; Vik & Rohde, 2014). Based on the child's focus expressed as signals, or "initiatives," the method identifies so-called "dialogue ele-

Three key findings and implications

1. Therapists describe a vulnerable subgroup of parent–infant dyads as posing specific methodical and ethical challenges for guidance. These are dyads with child protective issues, caregivers' insecurities impeding the therapeutic alliance, and caregivers with unsolved relational issues or mental health problems. *Implication 1*: These dyads represent a client group with specific requirements and should be identified early in the guidance process, for example, through assessment of the parents' vulnerabilities and child protective issues.
2. Adapting the guidance to the requirements of these dyads renders the role of the therapist pivotal and demanding regarding the alliance, therapeutic interventions, selection of video material, and therapists' own emotion regulation. *Implication 2*: There is a need for conceptual development of the method for vulnerable dyads.
3. Marte Meo therapists experience profound conflicting or distressing feelings in the triangle between caregiver and infant that influence the guidance and put a strain on the therapist, especially where child protective issues are present. *Implication 3*: There is a need for development of supportive structures such as a rationale for Marte Meo in child protection services contexts, routines for cooperation with parents' mental health treatment, access to clinical supervision, as well as expansion of training curriculum to cover the specific requirements of overburdened parents, the therapeutic relationship, and transference/countertransference.

Statement of relevance to the field of infant and early childhood mental health

Our research on video guidance for parent–infant dyads shows factors that hinder or facilitate guidance processes for a vulnerable subgroup of dyads with increased risk for infant development. Our findings have implications for the practice field and conceptualization of video guidance and increase knowledge about interventions at the intersection of infant mental health work and child protection.

ments" structuring the interaction. Therapist and caregiver agree upon a working goal, for example, "better contact." The therapist films everyday interaction moments of the dyad, analyses the film, and identifies the dialogue element that needs developing, for example, "the caregiver registers the child's focus and contact initiatives." For the reviewing sessions with the caregiver, the therapist chooses clips that show developmentally supportive interaction, or an interactional opportunity for it, related to the dialogue element in question. The review makes use of microinteraction sequences and stills (Aarts, 2008; Hedenbro & Wirtberg, 2012).

Psychotherapy research indicates that the therapeutic alliance and therapist factors contribute substantially to therapy outcome (Castonguay & Hill, 2017; Norcross & Wampold, 2018; Schore, 2012). The intersubjective conceptualization of Marte Meo suggests that the therapist may be particularly important in promoting good outcome, especially when working with relationship disturbances. However, while considerable challenges in the form of emotional strain and marked pressure on the therapeutic alliance have been described for therapists using other parent–infant interventions (Brotherson et al., 2010; Diaz Bonino & Ball, 2013; Sadler et al., 2013; Schore, 2012), and therapist–caregiver interactions in VIG have been described as "messy and complex" (Chasle, 2011), therapist challenges in Marte Meo guidance are scarcely examined. Method descriptions and theoretical models focus on the application of the method and the therapeutic stance (Aarts, 2008; Hawellek, 2015; Hedenbro & Wirtberg, 2012). Therapists are expected to base the "dialogue" with the caregiver on the same dialogue elements they apply on the film, to be warm, attentive, give information in a neutral tone, and lead the focus on the film and the child's signals (Hedenbro & Wirtberg, 2012). Vik and Rohde (2014) stressed the importance of the therapist's sensitivity towards the caregiver. Kiamanesh et al. (2018) examined what therapists in the child protection services (CPS) experience as negative method factors in Marte Meo. But a closer description of the inner work of the therapists, their experiences and handling of challenges, is lacking.

Neander and Skott (2008) explored how parents and therapists experienced successful guidance processes and showed them to be cocreated by parents and therapists alike, underlining the importance of the therapeutic relationship. They highlight the need for empirical research on unsuccessful guidance processes. Such an exploration will illuminate several aspects of Marte Meo for parent–infant dyads: the therapists' role and requirements in challenging processes, and aspects of the method itself with regard to these dyads that may be problematic or need adapting. Taking into account the therapeutic challenges described for other interventions with parent–infant dyads, there is an absence of empirical investigation of the specific challenges in Marte Meo guidance with parent–infant dyads in the existing literature.

To the best of our knowledge, no previous empirical studies have explored therapists' experiences with challenging or unsuccessful processes in this specific method. The aim of the present study was to examine what skilled therapists experience during Marte Meo video guidance processes they describe as difficult, and how they respond to these difficulties. Our main research questions were: What do therapists experience as challenging when conducting Marte Meo video interaction guidance with parent–infant dyads, and how do they handle these challenges?

2 | METHOD

2.1 | Methodology

We conducted a qualitative interview study based on a phenomenological-hermeneutic methodology (Alvesson & Sköldberg, 2009; Hill et al., 2005) and chose reflexive thematic analysis as a pragmatic method that would allow us an inductive, data-driven analysis (Braun & Clarke, 2019). A semantic approach was adopted, identifying themes within the explicit meanings of the data. We aimed at a reflective, experience-near reporting of the data. The analysis was carried out as a team-based approach (Binder, Holgersen, & Moltu, 2012) that further strengthened the balance between closeness to the participants' experience, drawing in theories, and reflecting on our own position as researchers.

2.2 | Setting

The study was embedded in a research project about Marte Meo video interaction guidance for parent–infant dyads. It was a collaboration between the Infant Mental Health Team, Department for Child and Adolescent Mental Health, and the Research Unit, both at Southern Norway Hospital Trust, Kristiansand, and the Department of Clinical Psychology at the University of Bergen, Norway.

2.3 | Participants

To examine the experience and handling of difficult guidance processes with parent–infant dyads, we aimed at a purposive sample of Marte Meo professionals with experience in guidance processes. We recruited Marte Meo therapists and licensed supervisors. Therapists have

undergone a 2-year postgraduate part-time supervised training and certification. Licensed supervisors are therapists with additional extensive experience in the training and supervision of therapists and training supervisors, representing the highest level of training in Marte Meo (Marte Meo International, 2020). Sample size was based on the concept of information power (Malterud, Siersma, & Guassora, 2016). Eighteen participants were contacted through training supervisors or directly by the first author. All contacted therapists and licensed supervisors gave written informed consent to participate in the study.

2.4 | Data collection

We devised a semistructured interview guide to assist the exploration of the lived experience of therapists during challenging video guidance processes (see the Appendix). It was used for both therapists and supervisors, but additionally, the supervisors were asked about their experiences from training and supervision regarding therapist challenges. The questions were broad to allow varied and personal descriptions. Participants were encouraged to engage actively in the discussion, pursue topics they found relevant, and supply concrete examples from guidance processes and their personal reflections.

We interviewed the therapists in focus groups, but for practical reasons the supervisors were interviewed individually. The first author conducted three focus group interviews, lasting from 80 to 116 min ($M = 98$ min), and four individual interviews lasting from 60 to 100 min ($M = 79$ min) by between November 2016 and January 2018. Interviews were audio-recorded, the focus group interviews also video-recorded, and transcribed verbatim. One focus group interview with five participants (therapists) was excluded from the analysis due to reasons of research ethics and confidentiality (i.e., one participant in a focus group became a study author, thus that group was dropped from analysis).

We included 13 participants in the analysis. Nine were video guidance therapists, two of whom also were training supervisors. They had several years' experience with parent–infant dyads, a varied professional background, and affiliation, had been trained at different training sites, and came from different geographical regions of Norway. Four participants were licensed supervisors, three from Norway and one from Germany. Therapists and licensed supervisors had backgrounds of social work, pedagogics, and family therapy. Some worked in primary health services or family guidance, some in specialized health services, some directly, or through commissions for the CPS.

2.5 | Data analysis

Data analysis was technically assisted by NVivo 11 software (QSR-International, 2015). A reflexive thematic analysis was carried out in a seven steps collaborative process (Binder et al., 2012; Braun & Clarke, 2012) by the first, second, and last author: (1) All collaborators familiarized themselves with the data and noted down their first impressions and reflections about the experience related in each interview. (2) The first author reread each transcript line by line, identifying meaning units, and generating 145 initial codes. Meaning units were understood as features of the data that appear interesting or seem to convey meaning regarding the phenomenon. A code was attached to the meaning units and a fitting code was found for each one. Existing codes were used across transcripts only if they were considered a suitable description. (3) The first author reported the initial codes back to the group. Across transcripts, 42 meaning patterns or subthemes, and four main themes were identified in a collaborative process, using the first impressions, the initial codes, and referencing back to the transcripts. (4) Themes were summarized and reviewed as a process back and forth between the first author and the group, maintaining the four main themes, and formulating 17 most relevant subthemes. (5) The first author refined the themes and wrote an analysis of each one. (6) The themes were drawn together in writing, related to the research questions. (7) The research team formed a consensus on the formulation of the four main thematic categories.

2.6 | Researchers

The first author is a child psychiatrist and research fellow, and the second and last authors are associate professors in clinical psychology. The third author is a sociologist and senior researcher. The first and third authors are video interaction guidance therapists specialized in infant mental health. All authors have extensive clinical experience with psychotherapy and other mental health care treatment approaches. The second, third, and last authors have experience with qualitative research on a range of topics in mental health.

2.7 | Ethics

The study was registered and approved by the Norwegian Federal Center for Research Data. Written informed consent was obtained from all participants. They were

informed that they could withdraw from the study at any point. No participant retracted consent to the study after the interviews.

3 | RESULTS

We identified four main themes in the participants' experiences and handling of challenging guidance processes: (1) promoting relational growth in a coercive context, (2) building an alliance that feels safe for the parents, (3) looking at positive moments in difficult lives, and (4) handling intense feelings as a therapist.

3.1 | Promoting relational growth in a coercive context

Guidance with parents of young children often raised issues of child protection or had the CPS already involved in the family. The first theme, "promoting relational growth in a coercive context," describes the two main challenges that the therapists experienced: the dilemmatic nature of using a resource-oriented method in a context of child protection; and the difficulty in establishing therapeutic work with parents in this coercive situation.

When working with seriously challenged families of young children, therapists were aware of child protective issues, but they felt these issues to be at variance with the resource-oriented stance of the method. They felt that time was pressing and could become worried when they did not observe signs of progress a short way into the guidance and thus experience a conflicting double role where they had to balance a therapeutic perspective with concern for the child's welfare.

They also became privy to interaction within the family during the guidance process. Where they saw severe problems, especially when the guidance process did not lead to observable change, should they report this to the CPS? How could they focus on highlighting instances of positive interaction when they also witnessed seriously dysfunctional exchanges?

> Sometimes you capture things on the film you'd rather not see … bordering on, was this abuse I just witnessed, or wasn't it? … Are you supposed to move on and just focus on what is positive … and are you supposed to forget what was not okay at all? (Martin)

The therapists expressed that the exclusively positive perspective of the video feedback could feel inadequate in the light of the difficulties they observed with the caregiving. They could also worry about whether the alliance with the parents and the decidedly solution-focused stance of the method might keep them from realizing that the overall care for the child was not sufficient. Were they helping to maintain an insufficient situation and could the guidance even supply parents with strategies to conceal problems in the family? "That is a dilemma … because you are supposed to float on the wave of [parental] achievement, and yet you see such serious things that you just have to mention," as one therapist put it.

> Marian: I get so elated with these parents. [laughing] I dance out of [the guidance].
>
> Tessa: We would so much like them to succeed –
>
> Marian: [laughing:] And this even though we have witnessed so many negative things
>
> Tessa: Yes. It is a danger. It certainly is.

The coercive context influenced the praxis of video interaction guidance in several ways. When the CPS were involved, they were a third party in the guidance process, pressing for change, demanding reports and embodying the implicit threat of the child being placed outside the family. The therapeutic relation was therefore less secure for the parents. They often seemed afraid and showed no intrinsic motivation for change, apart from yielding to external pressure. Furthermore, filming as the central tool in Marte Meo could appear in a different light to the parents, more as a measure of external control than a means for empowerment. Some parents had previous experience of film exposing their inadequacies and being used against them. This affected their expectations of Marte Meo and the alliance with the therapist. Building trust was difficult in this situation, and parental mistrust in the alliance appeared realistic. Often, parents seemed defeated when they entered the guidance, which was not a good condition for relational growth. A central aim was therefore to use the alliance with the therapist and the resource-focused use of film to help them feel more secure.

Even though there could be cases where Marte Meo turned out to be insufficient, therapists held that the method was well suited for seriously compromised families. As one said, "I experience this as the strongest tool I have as a therapist. … If you cannot engage them … and help them change through Marte Meo, what then?" The dilemma of trying seemed thus unavoidable, and therapists had developed their own practices to handle

the challenges. Negotiating the mandate with the CPS was important, and therapists had previously refused assignments without a clear division of mandates. The CPS were asked to clarify their objective for the guidance. Therapists could then explain their resource-focused approach to the parents and draw a clear demarcation between video guidance and other services. They could also meet the parents in their negative feelings about the coercive context, as a basis to help them develop their own objective for the guidance process. Therapists also stressed the possibility, even obligation, to prematurely end a guidance process when child protective concerns became dominant, and several therapists described that they had done this.

> Sometimes we inform the CPS at some point because [the parents] don't take in the guidance. Or because we see that the situation of the child isn't good enough. The infant doesn't get recognized and validated and so on. Those cases are quite tough, since reporting is not the first thing you do—but there Marte Meo is not enough. (Jenna)

3.2 | Building an alliance that feels safe for the parents

The second theme, "building an alliance that feels safe for the parents," describes the challenges that therapists met in establishing a safe therapeutic alliance with parents for whom this could be a novel and challenging experience.

Therapists felt that the therapeutic relationship was especially fundamental in the guidance of more vulnerable parents. Security had to be built up through concrete, repeated experience. "I feel we don't laugh freely before we reach the third film," said another. Accordingly, filming preferably took place at the families' homes where parents felt more secure and in charge. Therapists established a friendly rapport with them about safe, every-day topics before and after filming and refrained from engaging overly much with the child. Centrally, the element that gave parents security was the reliably positive way that therapists presented the interaction in the video feedback: short, every-day moments where parent and child had a developmentally supportive exchange.

> We have an exclusively developmental focus. … What is unique is that we look at what people themselves represent of possibilities and potential for change in such a way that they can learn from themselves, they learn from what they already can do. (Tim)

For some parents, guidance on their own caregiving seemed to be perceived as critical, hurtful to their self-esteem or like admitting defeat. This also influenced their motivation and made it difficult to agree on working points for the video feedback. Surrendering to being filmed in the interaction seemed to feel threatening for other parents. Some negotiated about the control of the video material, whereas others expressed they were too fat, ugly, or not good enough in other ways to be filmed, which seemed linked to more fragile experiences of self-worth. To handle these challenges, therapists introduced filming as soon as possible. Besides letting the parents experience how video feedback was used reliably and with a positive focus, the aim was to detract the attention away from themselves onto concrete aspects of the child and concrete themes in the interaction.

> They come with shoulders up here [hand under chin]. And after the review of the film, their shoulders are down there [hand at shoulder height]. Because … when I ask, how was it for you to come here, what did you expect? They thought I was going to criticize them. They thought I was going to say all that they didn't manage. (Jill)

Focusing on the child made the reviews feel safer for the parents, and easier to concentrate more on themselves as caregivers and less on their personal issues. Where parents were too diffident to be filmed at first, therapists offered to exclusively film the child or blur the parents' image in the video feedback. Therapists showed the child's face and expressions, and contact moments between child and parents. This awakened the parents' interest and opened up their own motivation.

When parents felt the security that issues were dealt with in a resource-focused way, they could start to take up concerns of their own, which they might not have shared with anyone before. Therapists also noticed that once parents had seriously embarked on the guidance process, sequences and pictures from the video feedback could linger in their awareness for weeks and months and influence their caregiving.

> The deeper you dive down into it, the more the parents recognize what they maybe need help for. … First when that door opens up you get these … potent moments, where … they are receptive and want to share their own experiences. (Martin)

The therapists drew information from the interaction with the parents to help them handle their feelings during the video feedback. The central processes seemed to occur between the interaction on the screen and the interaction between parent and therapist, requiring both intuition and deliberation from the therapist.

> This triangle … generates a force field that is about things that are triggered by the screen but played out in the dialogue. And about looking at what is going on in the person you are giving guidance to … not just what is in the film, but to have this double gaze … to catch the signals from the person receiving guidance, and at the same time consider whether, "is this something we should use now?" (Tim)

Therapists described how parents needed to be acknowledged and at times even emotionally held and supported to promote development in the guidance. They experienced that the positive, attentive, regulating stance they had towards the parents correspondingly influenced the parents, both in the stance towards the child and in how the parents acted in the caregiving relationship. As one therapist summed it up, this was centrally about "the experience to… not use your eyes to localize weaknesses, critical issues, problems, but learn to read [the child] through the power of a loving gaze."

3.3 | Looking at positive moments in difficult lives

The third theme is called "looking at positive moments in difficult lives" to describe therapists' experience of how Marte Meo guidance could be challenging for parents when psychological vulnerabilities became activated in the interaction with the child or during video feedback. Therapists found that some parents had a heightened vulnerability for certain feelings or caregiving situations. They could become either intensely emotionally activated or emotionally very distant in the interaction with the child or when they saw it on film, often unable to put words to their experiences. "Very often they cannot handle their own discomfort. They are used to shut out painful, difficult feelings, and instead of sharing them and moving on, they close down inside themselves," one therapist related.

Some parents seemed very sensitive to feeling rejected and could read normal infant behavior as dismissing, whereas others became very activated by feeling an emotional connection with the child. Some parents could react strongly when they experienced the child as unregulated or demanding, while others were insecure about how to set healthy boundaries in caregiving situations. These vulnerabilities could be related to known previous trauma, or to relational problems such as with personality disorders, but they also occurred in parents without a defined mental health diagnosis.

Therapists took these vulnerabilities into account when they chose the film clips for the video feedback, looking for positive sequences that would engage but not overwhelm the parents. Centrally, therapists described a markedly deliberate way of showing the films. They focused on the child, tracing the interaction repeatedly, stimulated reflection about what the child was expressing, and gave room to the parents' feelings. They monitored the parents' signals closely under the feedback session, because facing strong emotions about the interaction could feel novel and scary. This crucial new experience of sharing and being emotionally supported by the therapists seemed a precondition for some parents to be able to be emotionally supportive towards their own child. Many parents at this point made a connection to their own caregiving experiences and reflected on how these influenced the relationship with the child. "To recognize that 'this is about myself, this is not about what my child does' can help the mother to change," said one therapist. Other parents seemed more overwhelmed by the influx of memories and emotions connected with their own childhood and needed help to regulate their feelings.

> Sometimes this gets very heavy for the parents. They look back and realize, "God, I never got this myself. I was never met like this when I was a child." … So you also have to handle the feelings the parents uncover, which can be tough for them. (Martin)

Therapists balanced carefully between validating emotions belonging to the parents' past and focusing on the present interaction with the child. A central aim was to strengthen the parents as caregivers in the present moment and lead their focus to the films of the actual caregiving relationship.

> Many have a great need to be comforted and to share … what they experience with the child. … So I respectfully receive [their communications], back to "and now we focus on your child, now it is you who is the mother, so look at this." … I often feel I am skipping over something I could have gone much further

> into—but you don't know how deep that pit is. (Ruth)

Some parents shared delight and pride about their child for the first time, while others became painfully aware of situations where they had not met their child's needs and shared their sadness and regrets about it. Therapists also experienced that some parents did not connect with the interaction and persistently avoided focusing on the child. Some expressed anger and frustration about not understanding what the therapist was aiming at. With others, therapists experienced shared moments but then felt them close up again. Centrally, those parents seemed to have a more self-centered focus and seldom wondered what was going on inside the child; they could describe their child in a distant, negative or even hostile way.

> They are emotionally not present. Towards their child. They are more self-centered. Egocentric. … And that becomes very noticeable once you begin to show the film. … all that gets transferred is the problem, onto the child, the child is the problem. The child is difficult, the child wants to hurt me. (Christy)

Here, therapists used closely filmed details of the interaction to lead the parents' attention onto the child. They magnified facial expressions and used stills, focusing on eye contact and on how the child reacted to the parents. They traced the rhythm of movement, prosody, and atmosphere.

> There is something about the tone of voice, about the rhythm of talking to each other, about the contact, eye contact. And there is something about the atmosphere in the room or in the interaction that is so crucial for whether one can take the perspective of the other person or understand the other's feelings. (Tim)

Through this focus, some parents could see their child in a new way. A decisive element in this seemed to be whether they would recognize that what they saw on the screen was genuine, and not dismiss it as false or random. Therapists would then enhance this moment through repeats and stills.

> That is the power of the film, the power of Marte Meo. If you have just one moment that lasts two seconds, you can extend it to last a whole lifetime. You just have to press pause and let the picture come to a halt, and then just remain there and focus on the child. And … the parents sort of grow bigger in their chair, and move forward, and look at their child in a new way, in a new light. Because they have never seen this before. Because the moment is over when it is over, … and then you are back in the old groove. (Martin)

3.4 | Handling intense feelings as a therapist

The final theme, "handling intense feelings as a therapist," describes the therapists' inner experiences when they navigated difficult guidance processes. Though asked about its challenges, all therapists also highlighted positive aspects about video guidance. They found working with film both more effective and satisfying than merely talking about the interaction and described the potency of pictures and how they felt they were working closely with the families. Yet this proximity entailed challenges. "You are impacted by it … You come quite close, you know. And the parents really are struggling. So when you work with a vulnerable family, it leaves an imprint upon you," as one therapist expressed it.

Parents used the secure therapeutic space to open up also about their personal history and problems. Moreover, the filming and reviewing of close-up pictures of contact and emotions, often taken at home, appeared to enhance the feeling of privacy for some parents. They could express the need for more direct emotional feedback from the therapist which could require careful balancing.

> How are you supposed to react when they express their own feelings that can be so private and intimate and vulnerable? … Many of these mothers may have been failed by their own mothers, which makes them especially sensitive towards a woman guiding them, so they want a reaction. And perhaps there is something in a mother's feeling or in a woman's feeling … that [makes] you recognize all those feelings. You transpose it to the professional. But how shall you professionally support another woman in her role as a mother, without sounding pathetic? (Ruth)

The feeling of success, when therapists could help a parent to change the interaction and saw how this positively impacted the child, was joyful and even elating, especially when it had entailed a difficult guidance process and much regulating of the parent. "I took a film in the end where she

managed to comfort him. And … it turned. …—he suddenly began to look at her …—that was really magical."

But therapists could also experience that they did not manage to engage the parents in dialogue, even though they worked hard to establish a therapeutic alliance. "It was difficult to reach her at all. I felt that case was really stressing me out," as one said. Therapists could feel that they had something to give that the parents were not able to receive.

> I would use myself as an example [and say:] "Yesterday I saw a mother and son on the bus, talking with each other. I could see that the mother cherished what he was saying. And looking at them at that moment, I felt like I was in that bubble together with them." "Don't know what you are talking about." [says the parent] "But that was what I tried to take you into," I say, "I was trying to take you inside [the bubble] with me." (Ellen)

When they did not succeed to draw the parents into this "bubble," therapists could react with increasing eagerness, tempo, and explanations. "If I get too eager, this is suddenly about something else than it should be" said one; and another: "If we realize we are halfway over the table, we have to consciously relax." But they also described feelings of frustration and even despair: "When I experience so strongly that there is no progress, I feel sad and anguished. However, I can place that feeling. It's about myself and my own mother." These strong feelings could be enhanced by the awareness that the parents' change was sorely needed for the children.

When filming, editing, and reviewing, therapists looked closely and attunedly at the children. It was into this perspective that they tried to invite the parents in the reviewing process. During filming, therapists were trained to look for sequences of developmentally supportive interaction and usually would not interrupt even exchanges bordering on the dysfunctional. Yet this could feel wrenching. "Painful … to witness so much hostility. … like two five-year olds, fighting. It was really hostile. … That was so painful. To be there, witness and not intercept," one therapist recalled. It was especially distressing for the therapists to witness hostility, and how this impacted the child.

> A boy (was) sitting with his mother who was going to feed him from a jar with baby food … and he pointed at the glass, it had many pretty colors, you know. Whereupon the mother draws away the jar and says "No-ho-ho!" [laughs sneeringly] "You won't get that, oh no!", whereupon he just looks away and remains sitting. There were many similar episodes. … Looking back I think he shouldn't have remained in that home … I feel it like a [with emphasis] urgh, painful lump in my stomach. He shouldn't have remained there. … A lovely little boy [sighs heavily] oh, that is painful. (Christy)

These experiences impacted the therapists. "Sometimes you wonder … how many children actually live like this. So it also gets to you as a person." one said. To handle this, they highlighted the importance of reflection and supervision. Being able to share their experiences with a colleague, receive external supervision on concrete guidance experiences as well as regularly attend seminars and refresh their theoretical knowledge were cited as helpful.

> I turn onto myself right away … how I didn't do a good job, I didn't manage … for it didn't go well, I think. But then you reflect together with a colleague. … And then you think, yes, this was about myself, but it was also about something together with them [the parents]. That it didn't go so well has to do with factors both in the person you give the guidance to, and in yourself. (Ellen)

4 | DISCUSSION

We identified and presented the four main themes from the analysis of how the therapists/supervisors experienced and handled challenging Marte Meo video guidance processes for parent–infant dyads, ranging from context and alliance to process and the therapists' inner experiences and conflicts.

The first theme, "Promoting growth in a coercive context," shows how the therapists experienced a dilemmatic collision of child protection perspectives and the salutogenic focus of Marte Meo, despite following method recommendations for clearly defined roles (Hedenbro & Wirtberg, 2012). Earlier empirical findings from the CPS (Kiamanesh et al., 2018) identified unaddressed issues of trust and coercion, and lack of structure, as weaknesses of the method, yet it was regarded as suitable for the CPS, and its salutogenic stance cited as positive for client motivation and change. Our findings show, however, that this stance made the therapists more insecure about the validity and implications of what they observed in the interaction, and when a continuation of the guidance became unethical. The difficulty of balancing perspectives has been described for caseworkers in the CPS, and a reconciliation of perspectives seems best achieved by more fluid, less

dichotomous conceptions (Oliver & Charles, 2016). Still, this pragmatic shifting of perspectives may be more difficult for Marte Meo therapists commissioned by the CPS, or confronted with child protective issues, because of the decided emphasis on empowerment, and the lack of method adaptations and procedures for Marte Meo in these contexts. Marte Meo has method elements, like brevity, using home visits, concrete focus on interaction, and enhancement of parental sensitivity, which have been efficacious in other interventions in high-risk families (Bernard et al., 2012). But its nonmanualized variant lacks a structured approach and does not have an explicit attachment focus. Therapist have found a combination with the Circle-of-Security model useful (Kiamanesh et al., 2018).

The second theme, "Building an alliance that feels safe for the parents," describes the challenges of establishing a secure therapeutic space for parents who struggle with mistrust, insecurity and negative relational experiences. Aversion to video taking has been reported as a factor hindering the alliance for some clients (Wang et al., 2006). In their meta-analysis, Diener and Monroe (2011) showed that insecurely attached clients often battle with "distrust, a more negative self-representation, a wariness to engage intimately with others, a pressing need to be reassured of the love of others" and therefore have "a more difficult time cultivating an emotional bond, agreeing … on goals for treatment and on tasks to achieve those goals." For parents where child protection issues apply, as well as their own inherent issues of mistrust and insecurity, the threshold to feeling secure in the therapeutic alliance will be even higher. To overcome distrust and wariness, the therapists in the present study use the video guidance in an exclusively positive way. Centrally, they draw the parents into the present moment of the interaction on the screen. When they are able to help them connect with the pictures, therapists report that parents open up and markedly engage with the filmed interaction. This can be linked to Stern's concept of the "present moment" (2004) which highlights that "present moments (and critical moments that effectuate change) must have both a duration in which something happens and, at the same time, take place during a subjective 'now'" (p. 366).

The third theme, "Looking at positive moments in difficult lives," describes challenges in the guidance process through the parents' own psychological vulnerabilities. These challenges are handled by the therapists in a markedly deliberate and reflective manner. This is manifested in the way they support the parents emotionally and how they employ the film, choosing video clips that engage but do not overwhelm the parents. Their handling by far expands existing method descriptions of the review situation as a "communication," and of film selection guided by what particular visual "information" is "useful" for the parents' development, even though therapist attunement and reading of the parents' reaction are stressed (Aarts, 2008; Hawellek, 2015; Hedenbro & Wirtberg, 2012). Beebe's model of a psychodynamic video-feedback intervention (2003), which stresses the therapists' emotional "holding" and timing of the feedback, has been found relevant in Marte Meo guidance of postnatally depressed mothers (Vik & Braten, 2009). Our findings expand this more generally for parents experienced as relationally vulnerable. Therapists centrally employed their intuition in the emotional support of the parents and selection of video clips, moving from a communications model into the more complex landscape of psychotherapy. Video selection may be linked to Bromberg's (2008) concept of "safe surprises," providing novel, "excitingly 'edgy'" perspectives that at the same time do not overwhelm clients who have a history of relational trauma (p. 333). In video guidance, the "surprises" entail new relational experiences with the infant *and* the therapist. With parents who are emotionally disconnected, therapists use video clips that trace facial expressions of the child as well as the rhythm and atmosphere in the interaction. This resonates with the "visual-facial, auditory-prosodic and tactile-gestural communications" mediating the development of attuned interaction and attachment (Schore, 2012) (p. 56) and the "vitality forms" that Stern (2010) has linked to "implicit relational knowing" (p. 111). We suggest that the therapists try to activate this right-brain implicit competence in the parents to facilitate an emotional connection that is not defensively warded off.

The final theme, "Handling intense feelings as a therapist," describes the strong and at times conflicting feelings that the proximity to the dyad elicits. Therapists often experience emotional engagement for the infants. Parental negativity and hostility can therefore feel wrenching and moreover raise ethical questions. We get glimpses of therapists' turmoil and inner work from other methods entailing close contact with parent–infant dyads (Rosenbaum, Bain, Esterhuizen, & Frost, 2012; Sadler et al., 2013a). Diaz Bonino and Ball (2013) place these kinds of processes in the context of transference/countertransference. Our data, particularly the intensity and immediacy of the feelings described, support this theorizing. We suggest that the use of video has a profound effect on the therapists' emotional engagement on behalf of the infants which seems enhanced by their own exposure to close-up views of them, tracing microinteraction, when filming, editing, and reviewing.

How can our findings help us to more generally understand challenging factors in Marte Meo for parent–infant dyads and the role of the therapist? Our data indicate that the guidance of a vulnerable subgroup of dyads is experienced as markedly different, where all components of the intervention can be fraught with challenges: caregiving

can raise child protective issues, and caregivers' insecurities can impede the alliance. Centrally, they often struggle with extensive problems related to unsolved relational issues and manifest mental health problems. For these kinds of "overburdened" dyads, several elements have been described as useful in the guidance (McDonough, 1995) that resemble the salutogenic stance of Marte Meo. Our findings add a new aspect to video guidance with these dyads, in that the role of the therapist seems to become markedly more pivotal and demanding. This concerns the therapeutic alliance, emotional support and regulation of the parents, selection of the video material adapted to their emotional capacity and connectedness, and transference/countertransference. Diener and Monroe (2011) found that the same parental attachment traits that pose a risk for the dyad also render the therapeutic alliance difficult. Our findings show how the parents' vulnerabilities are played out in the therapeutic relation and in the filmed interactions, demanding emotional work from the therapists. The guidance "dialogue" becomes centered on implicit relational processes on the screen and in the relationship, to a great extent navigated intuitively. Our findings highlight video guidance for these dyads as a psychotherapeutic process (Schore, 2012) that bears relational challenges characteristic for psychotherapeutic change processes, and specific challenges linked to the use of video. Consequently, therapists have requirements as to the framing and structure surrounding the guidance, as well as adequate training and supervision. The challenges we identified may also be relevant for other guidance interventions with vulnerable parent–infant dyads. This may especially be the case for interventions with a salutogenic stance that can collide with child protective issues, for home-visiting approaches with more flexible frames and a higher degree of proximity to the dyad, and for video guidance methods where therapists handle their own reactions to close up films of the infant as well as the pressure on the therapeutic relation.

To improve practice and counterbalance the strain on the therapists, vulnerable dyads should be identified early in the process, preferably preceding the guidance, by assessing the parents' psychological vulnerabilities and child protective issues. For parents with mental health issues, the need for treatment, and cooperation with treatment services should be established. There is a need for a rationale for Marte Meo in CPS contexts, including knowledge about when to report incidents or terminate the guidance. Therapists need structures of regular peer-based and external supervision. Their training curriculum should cover the specific requirements of overburdened parents, the therapeutic relationship, and transference/countertransference.

4.1 | Reflexivity and methodical considerations

Reflexive thematic analysis is conceptualized as a "creative, reflexive, subjective," process (Braun & Clarke, 2019). Because subjectivity is present at all stages, reflexivity about how this might inform and influence the acquisition, analysis, and organization of the data as well as their interpretation (Alvesson & Sköldberg, 2009; Tufford & Newman, 2010) is central. In our analysis, it involved being "honest and vigilant about … own perspective, preexisting thoughts and beliefs, and developing hypotheses" and to "recognize and set aside (but do not abandon) … a priori knowledge and assumptions, with the analytic goal of attending to the participants' accounts with an open mind" (Starks & Trinidad, 2007). The first author is an infant psychiatrist practicing video guidance. This could support data acquisition and analysis but held the danger of contaminating participants' experiences with own preconceptions, for example, by too early conceptualization instead of remaining close to the data. Our team-based approach (Binder et al., 2012) supported the experience-near analysis through a critical moderation of the process by the last author, and auditing by the second author who had experience with therapeutic processes but not video guidance or infant mental health. Conceptualizing, including conceptualized language, was consciously set aside until the discussion of the findings. The third author, who had extensive experience with video guidance in infant mental health, was involved in the research design and final discussion, but not in the data analysis.

We chose a qualitative approach to the phenomenon of challenges in Marte Meo video guidance, investigating through the lens of the therapists' subjective experience as analyzed by a subjective team. This has inherent strengths and limitations. Regarding sample size and information power (Malterud et al., 2016), the analysis showed that the interviews contained much and varied information, while there were many similar and recurrent nodes across the participants, indicating a sufficient sample size to investigate the phenomenon. Including informants from geographical regions, training sites, and professional backgrounds may be seen as broadening and strengthening the data. A further question was whether the participants were able to describe the breadth of their experiences in the interview situation. To this aim, the interview guide was formulated openly and used only as a scaffold, giving room for participants' own train of thought and topics. In addition, the interviewer and first author explicitly welcomed all types of experiences before and during the interviews. As 9 participants were interviewed in three respective focus groups, group dynamics may have

influenced the data acquisition. The subjective impression of the interviewer was that the participants freely engaged in the interviews and spontaneously interacted with each other, which may point to a secure and encouraging interview situation.

The findings of the thematic analysis contain so-called shadowed data about the parents (Morse, 2001), which represent the therapists' subjective understanding of the parents in the guidance processes. This expands the scope of the themes but may limit the validity of the data. An important methodical limitation was that we did not interview the parents themselves about challenging video guidance processes, which may be necessary to fully understand the nature of the challenges in using Marte Meo. Also, our exploration is limited to accounts of participants' experiences and does not include other data such as the video material itself.

4.2 | Implications for research and clinical practice

The present study is the first qualitative investigation of therapists' experiences and handling of challenges in Marte Meo video guidance for parent–infant dyads. Our findings show the need for further conceptual development that includes the emotional regulation in the therapeutic relationship and through the medium of video for vulnerably dyads. Further studies should explore how vulnerable parents themselves experience challenges in the guidance and therapeutic ruptures. Research on the video material itself by methods such as interpersonal process recall (Elliott, 1986), conversation analysis (Fogtmann Fosgerau, Schöps, Bak, & Davidsen, 2018), or parental embodied mentalization (Shai & Fonagy, 2014) could expand our knowledge about the method. As well, too little is known about vulnerable dyads with older children, where patterns of interaction have become more established and the child may have more manifest mental health problems. A comparison of the manualized variant, VIPI, and Marte Meo for high-risk dyads, and studies on guidance based on previous assessment of parental vulnerabilities could yield insight on guidance mechanisms and strategies for a positive outcome.

For clinical practice, the finding that a vulnerable subgroup of dyads presents specific challenges and requirements for video guidance should lead to the recognition of this client group, with implications for structural and method development. Structurally, a rationale for Marte Meo in CPS contexts, cooperation with parents' mental health treatment, therapist supervision, and expansion of training curriculum seem indicated. For the guidance itself, early systematic assessment of the parents' vulnerabilities and child protective issues could facilitate an adapted guidance process.

5 | CONCLUSION

The aim of the present study was to investigate what skilled therapists experience during challenging or failing Marte Meo video guidance processes and how they understand and handle these challenges. Our findings show that therapists experience specific therapeutic and ethical challenges when guiding parent–infant dyads with child protective issues, caregivers' insecurities impeding the therapeutic alliance, and caregivers with unsolved relational issues or mental health problems. The therapists' role becomes pivotal and demanding regarding the alliance, therapeutic interventions, and their own need for regulation, supervision, and structure. Early identification of these dyads could facilitate better adaptation of video guidance. Therapists need supporting structures, clinical supervision, and training, addressing these challenges. Our findings suggest the need for method development also on a conceptual level.

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APPENDIX

Interview guide for Marte Meo therapists and licensed supervisors:

1. Can you state your name, profession and work affiliation, and how long you have been a Marte Meo therapist (or: licensed supervisor)?
2. How would you describe a guidance process that could be called "difficult"? Can you give some examples?
3. What, in your experience, does help in a difficult process?
4. What, in your experience, does not help?
5. Have you had processes where you experienced that the guidance did not have any effect?
6. How does a difficult process affect you as a therapist?
7. Would you like to share other experiences or reflections?
8. (For licensed supervisors only) In the training and supervision, what do therapists report as difficult? Which factors in processes do they experience as difficult?