# A qualitative inquiry of clinicians' relational experiences within a perinatal infant mental health service contextualised with quantitative analysis of outcome measures

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To my friends, I have missed you! Thank you for the hugs, for listening, for caring, for always making me laugh and for counting down the days with me! Thank you to my sister, brother and nieces for keeping me steady, I love you. To Tom, what a year to meet and how special it has been because of you. To my grandad, whose memory never ceases to make me smile and give me courage when feeling deflated and who would have delighted in this achievement. Lastly, to my mums Julia and Lucy for always helping me take perspective. Your love, care, and passion for what you believe in have sustained and inspired me.

## Abstract

Literature highlights the perinatal period as a time of increased risk for mothers and infants, particularly those who have additional psychological and social risk factors. Enquiry reports underscore poor outcomes and service engagement for mothers from marginalized social contexts wherein relationships with services can be characterized by avoidance, distrust and silencing. Nuanced understandings of these relational processes are lacking and important to explore in the context of research supporting the therapist-parent relationship as a mechanism of therapeutic change. Within a Perinatal Infant Mental Health Service (PIMHS), this research aimed to explore clinicians' relational experiences with the mothers and infants they work with, and their reflections on therapeutic change, and contextualize this with analysis of quantitative outcomes for mothers and infants engaged in PIMHS interventions.

A qualitative inquiry using semi-structured interviews was undertaken with ten clinician participants and analysed using thematic analysis (TA). Quantitative analysis using Reliable and Clinically Significant Change calculations was conducted for six parent-infant dyads using pre and post-intervention scores on the Clinical Outcomes in Routine Evaluation-Outcome Measure (CORE-OM) and Mother Object Relationship Scale-Short Form (MORS-SF), alongside descriptive changes according to the Meaning of the Child Interview and safeguarding statuses.

TA produced five main themes; 'the overbearing wider context', 'professional positioning', 'dyadic/triadic relating', 'the self in the work', and 'connecting and expanding understanding'. Results highlight the multifaceted nature of experiences of clinicians working within the PIMHS through which wider contextual, inter-professional, dyadic/triadic, and intra-professional factors impact upon the work. Quantitative analyses of outcomes indicated a mixed profile of the extent that parents appeared to benefit from the PIMHS and demonstrated little consistency of change across measures. The discussion raises questions regarding how to measure the impact of the work, and the centrality of inter-disciplinary shared understanding in supporting families. Clinical and research implications are presented in the context of the findings and methodological limitations.

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# 1. Introduction

## 1.1 Introduction overview

The chapter begins with a review of the current context and prevailing issues in the field of perinatal mental health practice and research. The theoretical foundations and accompanying empirical research regarding the parent-infant relationship according to attachment, mentalization and reflective functioning, and epistemic trust are outlined. The implications of these for the therapeutic relationship, and additional perspectives are discussed. The chapter then considers prevailing interventions and programmes intended to support parents and infants in the perinatal period, and reviews outcome literature concerning these. A systematic search and narrative review is provided concerning the contribution of qualitative research with clinicians regarding their relational experiences with clients to understanding the therapeutic process. The chapter ends with a summary and rationale for the current study, concluding with the current research aims.

## 1.2 Broad context of perinatal mental health

The perinatal period encompasses conception through to 12-months post birth (Austin, Priest & Sullivan, 2008). During this period women are at increased risk of poor mental health outcomes, with up to 20% of women in the UK developing a mental health problem during pregnancy or within a year of giving birth (Bauer, Parsonage, Knapp, Lemmi and Adelaja, 2014). The term 'perinatal mental illness' refers to a range of conditions including anxiety, depression, eating disorders, and postnatal psychotic conditions (NSPCC, 2013).

Growing evidence indicates that mental health difficulties during the perinatal period have adverse consequences for the early mother-infant relationship and child socio-emotional development (Murray and Cooper, 1997). Infants are a vulnerable population with the highest child mortality rates being for infants under one year of age (Wolfe, Macfarlane, Donkin, Marmot and Viner, 2014). Mothers may also be considered an at risk group with suicide a leading cause of death for women during the perinatal period (Bauer et al, 2014).

Given the risk to both parents and infants, and longer-term adverse outcomes to child psychosocial and brain development associated with mental illness during the perinatal period, calls for early intervention services have been increasingly made over the past 15 years, for example Lyons-Ruth, Wolfe and Lyubchik (2000). Despite this, perinatal and infant mental health services (PIMHS) remain an emerging specialist area lacking research and documentation (Myors, Schmied, Johnson & Cleary, 2014). In the UK, Bauer et al (2014) estimate that in 50% of cases perinatal depression (PND) and anxiety go undetected and more than 40% of localities provide no specialist PIMHS whatsoever. In England in 2005 a survey of specialist PIMHS found only 23% of NHS trusts provided both in-patient and community services and that the number of mother and baby units had reduced over the preceding decade (Oluwatayo & Friedman, 2005). The shortage of mother and baby units remains a current issue (NSPCC, 2013), as does research indicating problems in the implementation of PIMHS including poor access to resources, lack of integrated working and poorly defined professional roles and responsibilities (Rothera & Oates, 2008).

In response to evidence of a lack of service provision and emerging research, updated UK practice guidelines concerning the perinatal period and infancy have reinforced the requirement for specialist services in each locality and emphasized the centrality of the woman and her relational context particularly with her baby (National Institute for Health and Clinical Excellence [NICE], cg192, 2014). The updated Healthy Child Programme (Department of Health [DoH], 2009) highlights a need for support for parents in providing sensitive and attuned parenting, integrated services and a focus on children and families considered vulnerable via a model of progressive universalism. Similarly, the maternal mental health alliance launched the ‘everyone’s business’ campaign in 2014 to raise awareness of perinatal mental illness and call for UK wide access to the services recommended by national guidelines.

In the current political context of cuts to health and wider public services in which just 13% of the NHS budget goes to mental health services (O’Hara, 2015), estimates of long term economic savings through delivery of perinatal mental health services have been provided alongside research evidence in a bid for investment. Bauer et al (2014) estimate savings of approximately £8.1 billion for each one-year cohort of births in the UK through establishment of these specialist services. In addition to economic arguments, ethical ones are also made. Galbraith, Balbernie and White (2015) consider that early years services reflect the value, or lack thereof, placed on early emotional experience by society. They argue that babies and preschool children are easy to ignore for their lack of agency but that safeguarding their mental wellbeing is as relevant as any other age group. This marginalization of infants' wellbeing extends to mothers experiencing perinatal mental illness, particularly those considered to be within complex social contexts.

### 1.2.1 Women at risk of perinatal mental illness.

Research has highlighted a number of risk factors associated with perinatal mental illness. These include; maternal and familial history of mental illness, lone parenthood, teenage parenthood, unwanted pregnancy, recent adverse life events, early emotional trauma and childhood abuse, lack of social support, and socio-economic disadvantage (Edge, 2011). Similarly, substance misuse (Ross & Dennis, 2009) and domestic violence (Schmied et al, 2013) are further associated with poor perinatal mental health outcomes.

Although mental illness itself can be a barrier to engagement (Myors, Johnson, Cleary & Schmied, 2015), pregnancy can bring mothers into increased contact with services and may facilitate engagement. Pregnancy can provide new motivation for women experiencing mental health difficulties to seek support (Tuval-Mashiachi, Ram, Shapiro, Shenhave & Gur, 2013; Greene et al, 2008). Indeed, infancy is a period of higher heath care expenditure across the lifespan by virtue of which there is opportunity to make contact with parents at risk of or experiencing mental illness. However, paradoxically mothers most at risk of perinatal mental illness according to the factors above may experience more barriers to services than those less at risk.

Enquiry reports in recent years have highlighted issues faced by pregnant women with complex social factors, pertaining to women whose social circumstances may adversely impact on the outcomes of pregnancy for themselves and their baby (National

Collaborating Centre for Women's and Children's Health, 2010). NICE (cg110, 2010) gives examples of such social situations as; poverty, homelessness, substance misuse, asylum seeker or refugee status, being under the age of 20, and domestic abuse. Saving mother's lives (Lewis, 2007) found that socially excluded women were at higher risk of death during the perinatal period and were less likely to seek antenatal care early in pregnancy or stay in contact with maternity services than women in the general population. Women who booked appointments with maternity services later in pregnancy or missed more than four routine antenatal appointments were more likely to be; black African or Caribbean, experiencing domestic abuse, unemployed, substance misusers, or known to child protection services. Perinatal Mortality (2009) highlighted that women in the most deprived population quintile and women from black or ethnic minority groups had stillbirth and neonatal death rates twice as often as white women and women from the least deprived backgrounds. These findings frame an urgent call to improve and better understand the accessibility of PIMHS for women from complex or marginalized social situations.

### 1.2.2 Child protection proceedings and repeated losses to care.

Many of the risk factors mentioned above are relevant to the lives of mothers going through child protection proceedings. In a care profiling study of court proceedings for the protection of children brought under the Children's Act (1989) section 31, Masson et al (2008) found that 60% of cases involved children under five years and 25% of all applications involved new born babies. Of their sample, 51% of the mothers experienced domestic violence, 39% substance misuse, 31.5% mental health problems, 25% alcohol abuse and 12.5% had learning difficulties. Echoing the lack of service uptake outlined above for women within complex social situations, Masson et al (2008) found that in 41% of cases, families experiencing care proceedings were offered and refused services. Of particular concern to clinical psychology and mental health disciplines, the most likely to be refused were treatment for substance misuse and therapeutic services for adult mental health.

In England, although the increase rate in the number of care applications may be slowing (Broadhurst et al, 2015), care applications between April 2013 and March 2014 rose to 10,609 in comparison to 6,465 for the equivalent period between 2008 and 2009

(Children and Family Court Advisory and Support Service [Cafcass], 2014). Between 2007 and 2013, mothers linked to recurrent care proceedings concerning different children constituted 15.5% of the total sample appearing before the courts (Broadhurst, Harwin, Alrouh & Shaw, 2014).

The rates of recurrent care proceedings and lack of uptake of therapeutic services is concerning and suggestive of a disconnection between mothers most at risk of perinatal mental illness and the services which consciously aim to support them. Broadhurst and Mason (2013) note an absence of discussion surrounding "how and why history repeats itself" (p. 291) in this context. They draw attention to the high rates amongst mothers involved in child protection proceedings of experiences of physical and sexual abuse, neglect and socio-economic disadvantage serving as a legacy brought to parenthood, reminiscent of Fraiberg, Adelson and Shaprio's (1975) 'ghosts in the nursery'. The centrality of the child's developmental timeline can have costs for the mother's own, in which sufficient time is not provided by services for mothers to engage and make use of necessary treatment. Moreover, the process of proceedings itself has been associated with a period of exacerbated mental health difficulties for birth parents (Neil, Cossar, Lorgelly & Young, 2010). Within this context of loss, unmet need and no statutory requirement to provide parents with post-removal support, mothers may be at greater risk of unplanned pregnancy (Broadhurst et al, 2015).

### 1.2.3 Normative discourses of motherhood.

Accompanying shifts in practice guidelines such as those by NICE (cg110, 2010 & cg192, 2014) emphasizing a non-judgmental stance and awareness of women's contexts, is literature seeking an interpersonal and relational understanding of perinatal mental illness as opposed to dominant medical or purely psychological frames (Knudson-Martin & Silverstein, 2009). Despite women's shifting roles in the home and workplace over the last century, motherhood is a salient social identity with normative expectations reinforced through idealized depictions of 'the good mother' in the media, parenting programmes and informal social networks (Broadhurst & Mason, 2013).

In a meta-data-analysis of nine qualitative studies, Knudson-Martin & Silverstein (2009) used grounded theory procedures to develop an explanation of the relational context of PND (Figure 1.1). They drew three main conclusions: women with PND across samples took cultural expectations of the idealized ‘good mother’ very seriously which offered them little flexibility in navigating their own emotional experiences; stressful couple and family relationships contributed to emotional disconnection, with family, friends and healthcare professionals often silencing experiences that did not conform to cultural ideals; mothers with PND experienced shame, overwhelming isolation and alienation in which the remediation of PND was understood as an interpersonal experience requiring reconnection with others. Although on the surface appearing positive and celebratory, ideals of motherhood are unattainable and may undermine women’s sense of competence and invalidate their experiences (Douglas & Michaels, 2004).

In this context, experiencing child protection proceedings is a substantial challenge to a women’s identity as a mother and moral character (Slembrouk & Hall, 2003). The explicit focus of the care proceedings process on failures, to the sidelining of parental strengths, can leave parents feeling the process and professionals involved have been unjust (Broadhurst & Mason, 2013). Since the death of Baby P in 2008 there has been a 70% increase in new care applications (Cafcass, 2013). Broadhurst and Mason (2013) note a shift in social work practice towards child-centric approaches driven by anxieties regarding colluding with parents whose needs are depicted as dangerous and overwhelming for workers. In parallel, mothers may not know what changes they are expected to make nor understand the reasons or processes that have led to removal of their child with many remaining angry and ambivalent towards services (Welch, Gadda, Jones, Young & Lerpiniere, 2015; Broadhurst et al, 2015).

Research such as the above highlights the interpersonal context of perinatal mental illness, and defensive and normative processes that can see mothers relationships with professionals, among others, become characterized by avoidance, anger and silencing. It is of note therefore that there has been little research examining the nuances of these relational processes within the context of PIMHS (Knudson-Martin & Silverstein, 2009). Furthermore, in the process of child protection proceedings both the threat of removal of a child and possible withdrawal of services engaged with parents thereupon may replicate childhood experiences of loss and abandonment not uncommon in this population. The challenge for services is to provide a secure base for such mothers from which to foster change, although little is known about factors that promote or inhibit change (Broadhurst et al, 2015; Broadhurst & Mason, 2013).

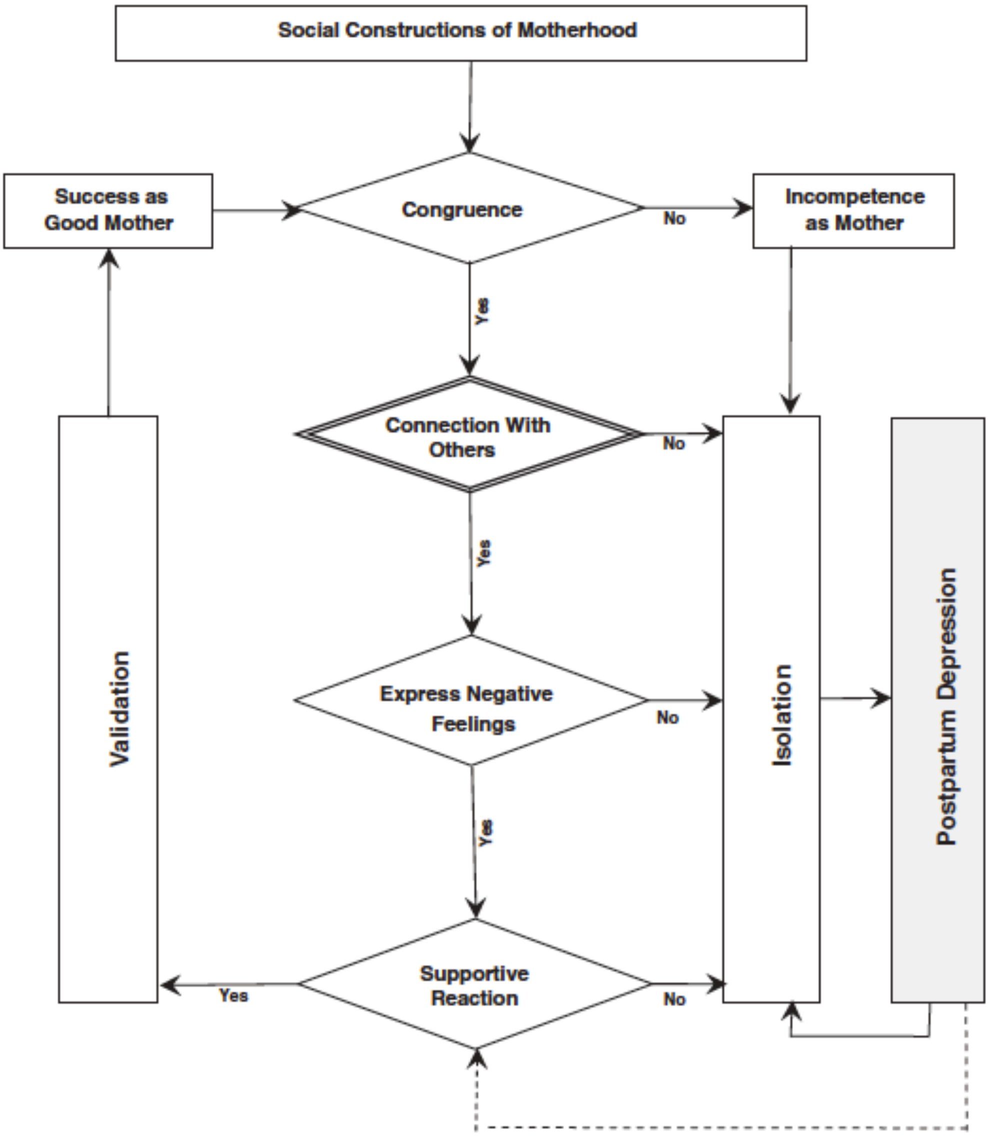


*Figure 1.1*: Model of relational processes affecting PND. Adapted from "Suffering in Silence: A Qualitative Meta-Data-Analysis of Postpartum Depression", by Knudson-C, Martin & R, Silverstien, 2009, *Journal of Marital and Family Therapy,* 35(**2**), p. 149. Copyright 2009 American Association for Marriage and Family Therapy.

### 1.2.4 The impact of perinatal mental illness on the child.

The interaction between infants and caregivers is of central importance to the development of the child (Mantymaa, Puraa, Luoma, Salmelin & Tammien, 2004). The assertion that the emergence of a ‘self’ arises only in relation to an ‘other’ runs through disciplines such as philosophy, psychoanalytical psychology, cognitive neuroscience and developmental psychology (Shai & Fonagy, 2013).

Interaction with a caregiver is the vehicle by which the social context of the environment is communicated to the child with compromises to the formation of a relationship incurring compromises for child development (Tronick & Weinberg, 1997). In conditions of high social contextual risk (such as parental depression, stress, lack of social support) the quality of the caregiver-infant relationship is predictive of socioemotional development and expressive language skills in the infant to a greater extent than in conditions of low risk (Belsky & Fearon, 2002). Exposure to stress and relational trauma in the early years has been shown to disrupt development of the infant’s regulatory systems with enduring and adverse consequences for right hemispheric brain function lowering an infant’s tolerance of stress and increasing vulnerability to mental health difficulties such as post-traumatic stress disorders (Schore, 2001). In relation to this, Zeanah, Larrieu, Heller & Valliere (2000) note the increasing focus of prevention and intervention work towards the parent-infant *relationship*, a focus that, with the above in mind, is of particular importance in contexts of high risk whereby violations to the parent-infant relationship are anticipatory of poorer child developmental outcomes.

## 1.3 A Pilot PIMHS

Local initiatives have been developed in recent years in an attempt to identify and support vulnerable women during pregnancy (Broadhurst & Mason, 2013). The UK government has made commitments to develop and build an evidence base for early intervention services and to refocus local services including children’s centres towards supporting the most disadvantaged families (Wright et al, 2015).

One such initiative, and the centerpiece of the current thesis, is a pilot PIMHS based in a seaside town in the East of England with a high level of social deprivation and higher than national average levels of care protection proceedings. The service will be outlined in detail in the proceeding chapter.

The service was commissioned to pilot the assessment and treatment five plus parents and infants involved in care proceedings. The focus was on early intervention directed towards the parent-infant relationship and parental mental health with a view to facilitating a safe and nurturing relational context in which the infant could remain with the birth parents. Research suggests shared knowledge of both child protection proceedings and mental health, and close working relationships between children's service and mental health services are vital in supporting marginalized women in the perinatal period (Lagan, Knights, Barton & Boyce, 2009). In line with this, as well as practice recommendations for greater integrated services (DoH, 2009), the PIMHS was established with a multidisciplinary, multi-agency core with representatives from children's services, health, mental health and community practice disciplines. With an overarching relational and attachment-informed theoretical foundation, the PIMHS intended to offer individually tailored, multi-modal support in which demarcated evidence-based approaches could be offered if indicated. The combination of evidence-based approaches used flexibly within a broader and individually tailored intervention allows support to be delivered in a contextualized way and may strengthen parents' participation in the process (Schrader-McMillan, Barnes & Barlow, 2012).

### 1.4 Theoretical foundations of the parent-infant relationship

Underpinning the broader context of perinatal infant mental health is a wealth of theoretical literature and accompanying empirical research. The current thesis, in compatibility with the theoretical foundations of the PIMHS, focuses primarily on theories of attachment and related constructs, and the implications of these regarding mechanisms of change in therapy and intervention design.

### 1.4.1 Attachment.

Attachment theory, originated by John Bowlby (1969, 1982), describes an innate mechanism with an adaptive evolutionary function through which babies elicit care in order to survive. It provides a framework for understanding how individuals navigate their intimate relationships and use different strategies, rooted in their pasts, to seek comfort and help (Fonagy, Lorenzini, Campbell & Luyten, 2014). Interactions between infants and their primary caregivers, attachment figures, are the initial basis for personality development and prototypic expectations for subsequent relationships regarding acceptance and rejection. In response to internal (psychological) or external (environmental) threats to safety, the purpose of the attachment behavioural system is to deploy attachment behaviours (for example crying, clinging) that increase proximity to an attachment figure promoting safety (Obegi, 2008). Once sufficient proximity is achieved the attachment behavioural system deactivates (Cassidy, 2008). Through repeated interactions with attachment figures mental representations, or internal working models, are internalized by the infant as they form understanding of the ebb and flow of themselves in relation to those around them. Ideally, the attachment process allows infants to use their primary caregivers as a safe haven to return to for comfort and protection when distressed, and as a secure base from which to explore the world in times of relative safety (Bolwby, 1988). However, Bowlby observed that a variety of attachment patterns could develop in childhood dependent on the primary caregiver's responses to the child's attachment behaviours (Gelso, Palma & Bhatia, 2013).

Ainsworth's seminal work using the Strange Situation Procedure (SSP) established three prominent attachment patterns (Ainsworth, Blehar, Waters & Wall, 1978). The SSP involves observation and assessment of infants' behavioural responses to periods of separation and reunification with a primary caregiver interspersed with time spent with a stranger in an unfamiliar setting. During the SSP *securely attached (or Type B)* infants explore their surroundings in the company of the primary caregiver, show anxiety upon the stranger's presence, become distressed in the absence of the primary caregiver, seek contact upon reunification with the primary caregiver and are reassured by this, after which they rapidly resume exploration (Fonagy et al, 2014). *Anxious/avoidant (Type A)* infants appear less upset by separation with their caregiver, may not seek contact when reunited with them, and may not obviously show a preference for the caregiver over the stranger. *Anxious/resistant (Type C)* infants show restricted exploration and play, become highly distressed upon separation from the caregiver and may not be easily reassured by reunification. Research by Main and Solomon (1990) identified a fourth pattern labeled *disorganized/disorientated (Type D).* Here, infants may show unsystematic or bizarre behaviours such as freezing and head banging, and may attempt to escape the situation. In addition to adding this fourth category, Main and colleagues (George, Kaplan & Main, 1984, 1988, 1996) developed the Adult Attachment Interview (AAI) to assess and categorize attachment patterns in adults at a representational rather than behavioural level, through narratives of their relationships and histories. Corresponding to the infant classifications respectively, adult attachment patterns have been categorized as; *secure, avoidant/dismissing, anxious/preoccupied,* and *unresolved/disorganized.*

Taking a different approach to attachment categorization, Crittenden (2008) developed the Dynamic Maturation Model (DMM) of attachment drawing on developmental and family systems theories, and emphasizing individuals' adaptations to past experiences of threat serving to protect themselves in the future (Farnfield, Hautamaki, Norbech & Sahhar, 2010). Genetic inheritance interacts with maturational processes and person-specific experiences producing individual differences in strategies acting to protect the self and offspring, and find a reproductive partner (Crittenden, 2005). The DMM strategies, or attachment patterns, are elaborated through development and context, and describe interpersonal behaviour as well as a system for describing psychopathology.

The organization of the strategies is the outcome of the brain's predisposition to process two forms of information: 'cognitive' information is acquired relating to the temporal order and intensity of stimuli through which individuals learn about causal relations; 'affective' information is collated regarding the somatic feelings associated with experiences through which levels of arousal regulate the body for self-protective action or exploration depending on environmental cues. The privileging of these two forms of predictive information, temporal and contextual, form two basic attachment patterns, Type A and C respectively (Crittenden, 2005). Individuals organizing according to a Type A strategy minimize awareness of feelings, privileging cognitive information regarding reinforcement or punishment of actions. Those using a Type C strategy show the inverse pattern, giving greater weight to affective information, such as fear and desire for comfort, to guide behaviour, and sideline cognitive information. In a Type B strategy the two forms of information processing are integrated allowing open and reciprocal communication of both expectations and feelings (Crittenden, 2005). Such information processing yields dispositional representations, akin to internal working models, acting as mediators for behaviour and stored across different memory systems. The DMM draws on eight memory systems clustered into four domains (Crittenden, 2008; Schacter & Tulving, 1994; Farnfield et al, 2010): biology (organic states and 'body talk'); cognition (procedural and semantic memory); affect/arousal (imaged memory and connotative language) and integration (episodic memory and reflective integration). The development of and ability to integrate representations across memory domains occurs through maturation (Crittenden, 2005).

Slade (2008) considers attachment theory's privileging of fear in the development of psychopathology to be the most radical and underappreciated tenet. Attachment theory holds that psychopathology and maladaptation arise as a function of fear of actual or perceived threat to survival including danger, loss and abandonment. Threats may be transient and mild or severe and enduring, coming from the primary caregiver or from others sources. The evolutionary drive to seek care requires a child to maintain a relationship by any means, even if the attachment figure themselves is a source of threat. Insecure attachment organizations result from adaptations to threatening contexts and give rise to distortions in behaviour, cognition and affect that act to regulate fear and distress (Lyons-Ruth & Spielman, 2004). These distortions in turn disrupt the development of capacities for affect regulation and self and other knowing and understanding (Fonagy, Gergely, Jurist & Target, 2002).

#### ***1.4.1.2 Prevalence, stability and intergenerational transmission of attachment patterns.***

Attachment research has predominantly focused on the categorization of attachment patterns, their stability across the lifespan, and predictive validity (Slade, 2004). Regarding prevalence Main, Kaplan and Cassidy (1985) found that 63% of children across community samples could be categorized using the SSP as secure, with 21% and

16% classified as avoidant and resistant, respectively. In a combined community sample of mothers in North America, Bakermans-Kranenburg and van Ijzendoorn (2009) classified 58% as secure, 23% as dismissing, 19% as preoccupied and 18% were additionally coded for unresolved loss or trauma, using the AAI. Taking this sample's categorization distribution as normative, they investigated deviations from this in clinical samples. Disorders with an internalizing dimension (such as borderline personality disorder [BPD]) were associated with greater preoccupied and unresolved attachments while those with externalizing dimensions (such as antisocial personality disorders) were associated with more dismissing and preoccupied attachments. Depressive symptoms were associated with insecure categorizations, and individuals who had experienced abuse or were diagnosed with post-traumatic stress disorder displayed greater unresolved attachment patterns. Bakermans-Kranenburg and van Ijzendoorn (2009) found only a few systematic associations between specific attachment patterns and specific clinical syndromes. In considering this “complicated picture” (p. 248) in which many clinical samples were associated with more than one category of pattern, they question the validity of categorizing attachment versus conceptualizing a continuum of patterns, and the applicability of a coding system developed with non-clinical samples for clinical groups. Indeed although Crittenden's DMM attempts to readdress this, Bakermans-Kranenburg and van Ijzendoorn (2009) call for more validation studies of the DMM strategies to confirm their empirical utility.

Research has indicated a relative stability of attachment patterns across the lifespan, with a 68-75 % correspondence between infant and adult classification (Fonagy et al, 2010). Longitudinal research suggests children with secure attachment histories, through the stable development of strategies to manage their emotions and social contexts, are rated by others as more empathetic and resilient and adept at sustaining relationships (Fonagy et al, 2014). However, of particular importance to mental health disciplines and therapy, attachment styles are not completely set in stone. Adverse life events such as abuse, bereavement and parental mental/physical illness are predictors of changes in attachment style (Waters, Merrick, Treboux, Crowell & Albersheim, 2000). From a different perspective, a secure attachment may also be ‘earned’ through integration of experiences that promote a balanced representation of safety and danger (Farnfield et al, 2010). Attachment styles can be stable across the lifespan but remain open to change through experience (Waters, et al, 2000), particularly when strategies no longer fit the context of their development (Crittenden, 2005). However, Bowlby's proposed 'defensive exclusion', by which individuals exclude new information about relationships that does not match their existing internal working models, suggests sustained and perceptible changes to the relational context are necessary to meaningfully effect attachment patterns (Wright et al, 2015).

Meeting the infant's innate drive to form attachments is the caregiver's capacity to provide a safe haven and secure base to the infant. Unlike the infant, the caregiver brings their own histories of relationships and experiences of comfort and distress (Slade, 2004), unconsciously interpreting the behaviour of the child through lenses shaped by these experiences (Belsky, 2005). This assimilation model (Belsky, 2005) assumes the quality of social bonds between parents and infants are intergenerationally transmitted (George and Solomon, 1999). That is, parents who have experienced sensitive, accepting and responsive parenting are better able to respond to their own children in emotionally nurturing and empathetic ways. A meta-analysis by van Ijzendoorn (1995) provided evidence of a 70% concordance rate of parent and child attachment patterns establishing an intergenerational transmission of attachment in contemporary Western society. In considering the mechanisms by which transmission occurs, van Ijzendoorn (1995) found 25% of the meditational effect could be accounted for by maternal sensitivity, that is sensitive and responsive parenting behaviours. Given this 'transmission gap' (van Ijzendoorn, 1995) in which the majority of the association could not be explained by maternal sensitivity, additional factors such as maternal mind-mindedness (Meins, Fernyhough, Fradley & Tuckey, 2001) and marital quality (Belsky, 2005) have been suggested as plausible mediators that might bridge attachment transmission. In the context of research on gene-environment interaction and epigenetics, it is also theoretically plausible that the attachment system may have evolved to render different individuals more or less susceptible to their rearing environment, which may also account for variance in the intergenerational transmission of attachment (Belsky, 2005).

Research such as the above, using categorization/classification as its centerpiece, has spearheaded the evolution of the attachment field. However, Slade (2004) has argued that this has been to detriment of a complex and dynamic understanding of attachment processes as manifest in clinical practice. Indeed, Fonagy et al (2014) remind that attachment classification is a summary variable encompassing various qualities of parent-infant relationship. The concept of mentalization, outlined below, may be one such quality and has gained attention in both clinical and research spheres as a possible mechanism by which parental psychosocial factors influence infant wellbeing and outcomes via the parent-infant relationship.

### 1.4.2 Mentalization and Reflective Functioning (RF).

Mentalization is conceptualized as the ability to envision mental states and understand one's own and other's behaviours as driven by underlying mental states (Fonagy, Gergely & Target, 2007). The term RF has been used to represent the operationalization of mentalization, that is the mental capacities that permit understanding the self and others in mental state terms (Gullestad & Wilberg, 2011). However, in many cases in the literature the two terms are used interchangeably. In the context of a parent-infant relationship parental reflective functioning represents the parent's capacity to perceive and respond to the infant as motivated by thoughts, feelings, intentions and desires (Shai & Belsky, 2011). Mentalization is hypothesized to have a bi-directional relationship with attachment. An inability to accurately conceive of the self and other in mental state terms may disrupt attachment formation and affiliation, and insecure attachment may inhibit the establishment of mentalization (Fonagy & Luyten, 2009). According to this understanding violations to this process leave an infant reliant on a simplistic, teleological understanding of the world using concrete, visible and physical outcomes to interpret events (Gergely, 2003). The cultivation of mentalization stems from the child's internalization of the caregivers' ability to represent the child's mental states and mirror the child's affective states in a manner that is coherent, marked, contingent and accurate (Diamond, Stovall-McClough, Clarkin & Levy, 2003). Mentalization capacity is thought to be intrinsic to affect regulation and social relationships, allowing an understanding that one's own and other's behaviours are predictably and meaningfully related to dynamic feelings and intentions (Slade, 2008).

Parental RF may be demonstrated by: explicit efforts and interest in connecting the infant's behaviour to underlying mental states; awareness of the opacity and difficulty in accurately recognizing mental states; and acknowledgment of the developmental context of mental states (Jurist & Meehan, 2009; Luyten & Fonagy, 2014). Conversely, low levels of parental RF may be indicated by: unfounded certainty or alternatively a lack of attributions about the infant's mental states; a tendency to make hostile attributions to the infant's mind; a limited ability to engage with the infant's internal world through imaginative play; and disinterest in the infant's mental states (Luyten & Fonagy, 2014; Suchman, Decoste, Leigh & Boelli, 2010).

Research investigating parental RF has primarily relied upon the RF scale developed by Fonagy Steele, Moran, Steele & Higgit (1991) as a measure of parental understanding of mental states. This coding system originally applied to the AAI and later to the Parent Development Interview (PDI) by Slade, Grienenberger, Bernback, Levy & Locker (2005), provides a numerical score of RF. Interview transcripts are coded from -1 (absence of RF or gross misinterpretation) to 9 (exceptional RF demonstrating complex and elaborate reasoning about mental states) that are incorporated into an overall score, with 5 representing a threshold of adequate but potentially simplistic mentalization. Fonagy et al (1991) found parental RF scores correlated significantly with infant security based on the SSP. RF may act as a protective and mediating factor in the contexts of social adversity and trauma in preventing intergenerational transmission of attachment patterns (Slade, 2002). Research has shown that high maternal RF is predictive of secure attachment classification in infants in the context of mothers classified as insecurely attached (Fonagy et al, 1995) and that high maternal RF is associated with effective mother-infant affective communication (Grienenberger, Kelly & Slade, 2005). In this latter study, Grienenberger et al (2005) suggest that rather than general maternal sensitivity as first hypothesized by van Ijzendoorn (1995), it is misattunement between the parent's and infant's minds in times of stress mediated by intrusive, hostile, fearful or withdrawn behaviours that is critical in attachment transmission and the infant's development.

More recently, Fonagy and Luyten (2009) have conceptualized mentalization as acting along four functional domains: automatic - controlled; self - other oriented; internally - externally focused; and cognitive - affective composition. Capacity to mentalize may vary to greater and lesser extents along these domains, for example in conditions of threat and high arousal capacity for conscious and controlled mentalizing may diminish in place of automatic mentalizing. Knowledge of an individual's capacity to mentalize along these domains has clinical implications both for the focus of treatment, for example in supporting enhancement of self-oriented before other oriented mentalization (Suchman et al, 2010), and in formulating how the therapeutic relationship may unfold (Luyten & Fonagy, 2014).

### 1.4.3 Epistemic Trust.

Epistemic trust is defined as an individual's willingness to consider new knowledge from another as trustworthy, generalizable and relevant to the self (Fonagy & Allison, 2014). Predicated on work by Csibra and Gergely (2009) concerning human transmission of culturally relevant information, Fonagy and Allison (2014) propose a developmental triad of attachment, mentalization, and epistemic trust. Within the context of a secure attachment relationship, an infant's natural epistemic vigilance is relaxed allowing them to accept and trust what is being communicated. In this state of epistemic trust, the infant is open to social communication and learning including their interest in the thoughts and feelings of the parent, thus strengthening the infant's capacity to mentalize. In contrast, in the context of disrupted attachment and chaotic or dangerous early experiences, epistemic mistrust and hypervigilance may ensue. In this state the infant may reject or misinterpret social knowledge and communications in other contexts as having hostile intent.

Fonagy and Allison (2014) suggest that facilitation of mentalization and epistemic trust and the social learning process this enables is key for psychotherapeutic change. The process of therapeutic change may parallel the developmental origins of mentalization, epistemic trust and attachment (Luyten & Fonagy, 2014). Having our subjectivity understood and mentalized triggers the ability to receive and learn from social experiences within and outside the therapeutic context. They state "in the absence of trust, the capacity for change is absent" (p. 12). In a state of epistemic mistrust or vigilance, an individual is closed off to new information or experiences in therapy and may be considered hard to reach from the therapist's viewpoint (Fonagy & Allison, 2014). This may be of particular relevance to perinatal mental illness and child protection proceedings in which women in these contexts are more likely to have experienced adverse and traumatic childhood and life events (Edge, 2011) that are hypothesized to disrupt epistemic trust. Similarly, high rates of service refusal and distrust of professionals among women experiencing child protection proceedings (Masson et al, 2008; Broadhurst & Mason, 2013), raise questions regarding how professionals aiming to support these women engage with these relational processes.

## 1.5 Implications for the therapeutic relationship and process

Many researchers draw the parallel of the mother-infant and therapist-client relationship. Additionally, more recent perspectives from both psychoanalytic and systemic approaches emphasize the co-constructional nature of therapy (Slade, 2008). Theory and research regarding constructs such as mentalization and attachment has provided a fruitful basis for understanding parent-infant relationships and mechanisms by which parental states of mind may impact on the developing infant. These theories also have important implications for the therapeutic process and how the client and therapist come to affect each other.

### 1.5.1 Client therapist relationship.

From the parent-infant psychotherapy field, Woodhead (2004) writes that therapeutic change is dependent on the development of a new relational experience created within the parent-infant-therapist system. Therapists take a mentalizing stance towards the parent-infant dyad to provide the experience of another mind connecting with their own to process experience in a manner that is consistent, secure and committed paralleling the importance of this stance within the parent-infant relationship (Broughton, 2005). Diamond et al (2003) have researched the bi-directional nature of mentalization in the context of therapeutic relationships to find that levels of therapist and client RF are mutually and reciprocally influential. Their research concludes that in order that a client use the therapeutic relationship as a secure base from which to develop the capacity to mentalize, the therapist's and client's RF need be neither too differentiated nor too aligned, but complementary. Such research echoes writing by Slade (2007) that particularly in the case of parent's deemed high risk, parental capacity to contemplate an infant's mental states is dependent on the clinician's capacity to contemplate the parent's mind. This capacity is consider by Cologon (2013) as fundamental to the mechanism of change. The dynamic and co-constructional nature of RF is illustrated by a finding by Diamond et al (2003) in which the same therapist demonstrated varying levels of RF in relation to different clients.

Researchers investigating the nature of attachment representations in the process of therapy have made related observations. Hardy et al (1999) and Rubino, Barker, Roth and Fearon (2000) found clients' attachment classifications predicted whether therapists responded in more 'cognitive' or 'affective' ways. Dismissing clients tended to be responded to by therapists with more suggestions and interpretations whereas preoccupied clients tended to receive reflections and exploration of feelings from therapists. Slade (2008) has referred to this mirroring as responding 'in style'. Through a review of the literature she suggests that therapists classified as secure may be more able to respond 'out of style'. The ability to flexibly respond to clients in complementary or noncomplementary fashions, mirroring or challenging respectively, may facilitate therapeutic change (Slade, 2008).

Gelso, Palma and Bhatia (2013) used attachment theory as a basis for understanding transference and 'the real relationship' in therapy. They consider transference as the client's perceptions and experiences of the therapist that are informed and driven by past experiences. Gelso et al (2013) define the real relationship as the personal relationship between people characterized by a genuine and realistic perception of the other. They suggest therapeutic relationships may contain elements of both secure and insecure attachments. Through a strong real relationship, a client may use the therapist as secure base and safe haven indicative of a secure attachment. However, within the transference less conscious, insecure attachment representations may also be evident. Gelso et al (2013) provide a nuanced understanding of attachment in the context of clinical practice. Research relying on categorical classifications and measurements of these complex constructs at demarcated time points is likely to oversimplify an understanding of their manifestation and relevance in clinical practice.

Literature in this area is in its infancy. There has been little consistency with regards to client populations, therapists and treatments considered across studies (Slade, 2008). Interviews such as the AAI and PDI provide insights into the nature of RF towards the self and others as well as in specific relationships. Their application, for example to the therapeutic context, may be illuminating (Luyten & Fonagy, 2014). Research investigating the nature of these constructs in the therapeutic relationship has predominantly relied upon quantitative methods investigating associations between attachment classifications and therapy process and outcome measures. Less is known regarding how therapists assist in promoting RF and integrating attachment representations (Daly & Mallinckrodt, 2009) and how therapists draw upon and are influenced by these constructs in their relationships with clients in order to promote change (Burke, Danquah & Berry, 2015).

Research investigating and delineating these relational processes from clinician's perspectives would be useful to both experienced and trainee therapists (Slade, 2008). Indeed, Steele and Steele (2008) suggest attachment strategies and mentalizing should be a central component of therapeutic trainings. Flexibly and consciously responding to clients from within the therapeutic relationship can be difficult. Descriptions of these processes could contribute to awareness of countertransference and negative therapeutic reactions (Slade, 2008). Such research in the context of perinatal mental health and child care proceedings may be particularly revealing whereby women at risk of experiencing these are more likely to have been exposed to childhood traumas that may be evoked in the therapeutic relationship. Similarly, the status of experiencing perinatal mental illness and care proceedings places women at odds with cultural ideals, which therapists themselves may be influenced by. For a deeper understanding of how therapists' RF and attachment representations manifest in the therapeutic process it is necessary to move beyond pre and post evaluations of categorical measures and investigate relational interventions using both quantitative and qualitative methods (Schauenburg et al, 2010).

### 1.6 Additional perspectives

Both Slade (2008) and Fonagy and Allison (2014), among others, have advocated that attachment and mentalization perspectives can usefully inform psychotherapies across disciplines without sidelining other clinical ways of understanding.

Farnfield and Holmes (2014) discuss how attachment can be conceptualized as an intra-personal, inter-personal and social psychological theory that, drawing on family systems theory, conceptualizes a series of inter-nested systems around individuals. Farnfield (2008) considers this perspective in an ecological model of parenting in which the child's attachment system is nested within the caregiving system that in turn is encapsulated by concentric systems including the spousal, family, community, and cultural and socio-economic systems. Changes at one level of the inter-nested systems will impact on other system levels. In the context of parenting this allows a framework for understanding how interpersonal and environmental factors may interact to produce both risk and resilience in the parent-infant relationship (Farnfield, 2008). Indeed, the high rates of women experiencing perinatal mental illness and child protection proceedings from marginalized and adverse contexts is indicative of the importance of attending to the social and ecological, as well as psychological, factors at work. Exposure to violence, substance abuse, poor housing and poverty can impinge on parenting ability (DeJong, 2014). The nuanced relationships between children, siblings, and peers are also important factors in child development, and may be comprised of elements such as intimacy and trust which are usefully conceptualized through attachment and mentalization and others which are less so, such as humour and fantasy (Dunn, 1993). It may not be possible to explain the complexities of human psyches, relationships and contexts by a unifying theory (DeJong, 2014).

Although proponents of RF and attachment understandings assert these may usefully and benignly transfer across psychotherapies, stronger criticisms exist. The universality of attachment theory is debated whereby what is considered optimal and secure may vary across cultures. Western societies may tend towards individualized, self-reliant and distant ways of relating in comparison to collectivist societies valuing interdependence (Rothbaum, Weisz, Pott, Miyake & Morelli, 2000).

Feminist critiques consider the historical and cultural context in which attachment theory was developed questioning the prevailing ethics and means by which mothers are scrutinized over being 'good enough' without recourse to their social situations and positions, or normal ambivalent and hateful maternal feelings (Orbach, 1999; Franzblau, 2002; Jordan, 1997). However, a more contextualized understanding of parental attachment and RF is emerging, particularly through qualitative studies (Cox, 2006).

Criticism exists in relation to medicalised diagnoses of ‘reactive attachment disorders’. The validity of this diagnosis has been questioned whereby its criteria draw heavily from literature concerning the social behaviour of maltreated children without sufficient integration of developmental research from the attachment tradition (Zeanah, 1996). Slater (2007) considers that the diagnosis seemingly equates more to a ‘disorder of maltreatment’ that pathologizes the child for experiencing a disruptive early environment.

These additional perspectives and criticisms draw attention to the wider cultural and social systems which surround and influence parents, infants and their relationship across time. They have implications for the extent to which it might be expected that interventions predicated and informed by theories of RF and attachment can be successful in reducing distress and facilitate relationships in complex contexts. Attention will therefore now be paid to outcome literature examining interventions intended to support parents and infants in the perinatal period, with a particular focus on those drawing on attachment and RF theories.

## 1.7 Outcome literature

Obegi and Berant (2009) distinguish between attachment-informed and attachment-based psychotherapy. The former describes the use of attachment theory and research in supporting the processes of assessment, formulation and intervention within other therapeutic models. The latter uses attachment theory as a conceptual framework for interventions seeking to change and assess attachment patterns or representations via validated attachment measures (Farnfield & Holmes, 2014). There is a wealth of outcome literature, focusing on a diverse range of attachment-informed interventions ranging from parent-infant psychotherapy to home visiting programmes (Barlow et al, 2010). This section will focus on the characteristics and efficacy of some of the salient interventions based on or informed by attachment for parents or parents and their infants, particularly those considered to be from high risk, complex contexts of relevance to the current thesis. Although some of the attachment-informed interventions comprise a behavioural component for example seeking to enhance maternal sensitivity and response as opposed to purely intervening at the level of representation (Barlow et al, 2010), interventions predicated primarily on social learning or behavioural theory focusing on parenting skills will not be covered.

### 1.7.1 Programmes and interventions.

Three notable examples of attachment-based interventions are Attachment and Biobehavioural Catch-up (ABC, Dozier, Lindhiem & Ackerman, 2005), ‘Minding the Baby’ (Slade, Sadler & Mayes, 2005) and the Circle of Security (COS, Cooper, Hoffman, Powell & Marvin, 2005). The ABC is a manualized, 10-session intervention for foster parents and parents deemed high risk by child protection services. It aims to raise awareness of how caregivers’ histories may be evoked in interactions, and decrease frightening caregiver behaviour in place of predictable, sensitive care to enhance children’s relationship formation and ability to regulate their behaviour (Bernard et al, 2012). The focus is thereby on changing parenting behaviours rather than mental representations in isolation (Juffer, Bakermans-Kranenburg & van Ijzendoorn, 2014). In a series of studies Dozier and colleagues found ABC improved foster infants neurobiological regulation of cortisol, their cognitive flexibility and theory of mind skills compared to controls (Dozier, Peloso, Lewis, Laurenceau & Levine, 2008; Lewis-Morrarty, Dozier, Bernard, Terracciano & Moore, 2012). In a sample of children with parents deemed as high risk of maltreatment, the intervention group showed significantly lower rates of disorganized, and higher rates of secure, attachment (Bernard et al, 2012).

‘Minding the Baby’ is an interdisciplinary, mentalization-based intervention and home-visiting service encompassing case management, parent and parent-infant psychotherapy, and crisis planning. It supports women identified as high risk, beginning in the antenatal period, with an overarching aim of improving parent RF and infant attachment security (Sadler et al, 2013). Preliminary results of the intervention found intervention families had lower rates of rapid subsequent pregnancy, higher rates of child immunization, and lower rates of child protection referrals at 12 months. Teenage mother-infant interaction was less likely to be disrupted at four months and all intervention infants were more likely to have secure, and less likely to have disorganized, attachment at one year. For mothers considered most high risk, both self and child oriented RF improved over the course of intervention (Sadler et al, 2013). In the UK, Minding the Baby has been adapted into a nine-session perinatal psychoeducation programme for parents considered ‘hard to reach’, called Baby Steps (Sanger, Haynes, Mountain & Bonett-Healy, 2015). The programme encompasses a home visit, six antenatal group sessions and three post-natal sessions focusing on strengthening parent-infant and couple relationships, support networks, self-esteem, and infant development. Initial evaluation indicates increased parental reports of attachment and feelings of warmth towards their baby, lower rates of adverse birth outcomes in comparison the general population, decreases in parental anxiety and improved relationship satisfaction among those least satisfied in their relationships at baseline (Coster, Brookes & Sanger, 2015).

COS encompasses a 20-week group based programme aimed at increasing parental understanding of their child’s attachment needs (Cooper et al, 2005) and is adaptable for individual therapy (Zeanah, Berlin & Boris, 2011). It integrates psychoeducation on attachment and child development, with group discussions and uses video feedback of interactions, including the SSP, to draw attention to children’s subtle communications of emotional need and moments of positive parent presence. In a perinatal COS intervention with mothers with a history of non-violent offences and substance abuse, the intervention group saw rates of infant attachment security and disorganization comparable to low risk samples (Cassidy et al, 2010).

Parent-infant psychotherapy shares the relational focus of attachment theory (Zeanah et al, 2011). Psychotherapists join the parent and infant to focus on the parent-infant relationship, parental representations and practices, in the context of a range of problems including attachment difficulties and abusive parenting (Barlow et al, 2010). A systematic review of dyadic psychotherapy including RCTs found that parent-infant psychotherapy and psychoeducation both improved mother-infant interaction and that parent-infant psychotherapy was effective in promoting secure attachment rates in intervention infants with mothers with depression equivalent to rates in a control group of infants with mothers without depression (Doughty, 2007; Cicchetti, Rogosch & Toth, 2006). In a study with mothers at risk of child maltreatment and neglect a combined intervention of parent-infant psychotherapy and developmental psychoeducation demonstrated improved maternal sensitivity, responsiveness and reciprocity at a three-year follow-up (Osofsky et al, 2007). One RCT compared parent-infant psychotherapy to the infant-led dyadic psychotherapy Watch, Wait and Wonder (WWW, Cohen et al, 1999). In comparison to the parent-infant psychotherapy group, the WWW group saw a greater shift towards secure attachment, greater improvement in infant cognitive development and emotional regulation, higher maternal satisfaction in parenting and decreases in maternal depressive symptoms. Both groups saw reduced parental stress, maternal intrusiveness and presenting problems, and improved quality of the mother-infant relationships. Differential group effects disappeared by the six-month follow-up with the parent-infant psychotherapy group seeing equivalent improvements (Cohen et al, 2002).

The significant attention parental sensitivity has received as a possible mediator and intervention target for establishing secure attachment has been influential in informing video-based programmes. The Video-feedback Intervention to promote Positive Parenting (VIPP, Juffer, Bakermans-Kranenburg & Van Ijzendoorn, 2008, 2009) is a short-term, home-based intervention aiming to promote parental sensitivity by reinforcing moments of sensitive parenting witnessed in video clips of parents with their infants. Discussions between a therapist and parent focus on accurately perceiving and interpreting the infant's signals and promoting parents' efforts to respond to these. Holmes (2014) describes this as an inherently mentalizing process whereby reflections concern how to observe and link external behaviours to internal states. RCTs of VIPP have demonstrated significant increases in maternal sensitivity and reduction in child externalizing behaviours at follow-up in a sample of insecurely attachment mothers from low socio-economic contexts (Main, Goldwyn & Hesse, 2003; Klein Velderman et al, 2006), and improved mealtime interactions and responses to infant cues in a sample of mothers with eating disorders (Stein et al, 2006). Although research indicates a significant medium effect size of VIPP interventions for promoting sensitive parenting, conclusions cannot be drawn with respect to the extent that VIPP enhances attachment security, in part as this has not been widely assessed in VIPP studies (Juffer et al, 2014).

Video Interactive Guidance (VIG) is an additional short-term intervention drawing on video feedback and delivered through home visiting. VIG was developed by Biemans (1990) and is based on Trevarthen's (1979) intersubjectivity theory, with a basis also in attachment theory (Schrader-McMillan, Barnes & Barlow, 2012). Through video clips parents are guided to reflect on their successful interactions and moments of attunement with their infants, in a process championing the overarching values of respect and empowerment (Cross & Kennedy, 2011). In a sample of mothers with depression an RCT investigating VIG demonstrated enhanced sensitivity and improved mother-infant interaction, greater infant attachment security and social competence in comparison to a control group receiving parenting support by telephone (van Doesum, Riksen-Walraven, Hosman & Hoefnagels, 2008). A smaller RCT using VIG with mothers with depression and infants aged six to 12-months found no lasting effects for VIG at a five-year follow up except for families who had experienced adverse life events. In those cases, the VIG group saw fewer externalizing behaviours in the infants suggesting early intervention might act as a buffer (Schrader-McMillan et al, 2012).

Infant/baby massage, where carers gently stroke the infant using rotational movements, has been used in community practice as a technique to improve parent-infant interaction, parental sensitivity to infant cues and reduce PND (Barlow et al, 2010). A review by Underdown, Barlow, Chung and Stewart-Brown (2006) suggests it can enhance mother-infant interaction, sleep and relaxation, and infant regulation of stress hormones. Further research is required with respect to its efficacy in improving interaction, although the Healthy Child Programme (DoH, 2009) considers the use of baby massage, and promotion of skin-to-skin contact more generally, with mothers from disadvantaged background or mothers with depression.

Alongside demarcated interventions and packages are organizational initiatives to support mothers and families in the perinatal period. The development of the Sure Start local programmes (Glass, 1999), described as the biggest revolution in early years services by Galbraith et al (2015), aimed to promote children's health, psychosocial, and educational wellbeing early in life. It emphasized community outreach and interdisciplinary working with services designed to respond to local needs rather than prescribing a manualized approach. The core domains of the service encompassed home visiting, family support, promoting quality play, and learning and childcare faculties (Schrader-McMillan et al, 2012). Evaluation of the initial Sure Start programmes (Belsky et al, 2006) demonstrated some positive effects in terms of fewer behaviour problems and greater social competence in infants from less deprived families. However, it was not successful in enhancing child development or parenting for the most deprived families including those experiencing unemployment, or single parent and teenage parent families. Schrader-McMillan et al (2012) suggest this may be indicative of the barriers to services such families experience. Since the re-organisation and integration of Sure Start into children's centers in 2005 improvements in parenting and infant wellbeing have been demonstrated in families from disadvantaged backgrounds, although the lack of involvement from adult mental health services remains an issue for the extent that the needs of all family members can be supported (Galbraith et al, 2015).

### 1.7.2 Efficacy and issues.

A recent systematic review and meta-analysis by Wright et al (2015) examined the effectiveness of early parenting interventions for children with 'severe attachment problems', defined as those with disorganized attachment patterns or attachment disorder diagnoses.  Searches provided 29 RCTs for the main review of parenting interventions, of which eight were incorporated into a meta-analysis. The interventions reviewed included VIPP, parent-infant psychotherapy, COS, ABC, home visiting and psychoeducation programmes, Cognitive-Behaviour Therapy (CBT), psychodynamic psychotherapy and counselling. Demographics across studies included samples with parental mental health issues, low and middle socio-economic backgrounds, poor parenting practices, children with maltreatment histories, and teenage mothers. The quality of the studies suffered from high rates of bias including incomplete outcome data with rates of attrition often 10% or higher, selective reporting of results with minimal reporting on secondary outcomes such as quality of life and functioning, and other biases such as small sample sizes, and incomplete reporting of randomization and group allocation. Many interventions were multi-faceted incorporating home visits, video training, family therapy and sensitivity training, and were largely dyadic rather than working with the parent alone. Overlapping foci of the interventions were positive feedback for carers, exploration of parental perceptions of the child, improving parental attachment to the child and promoting sensitive caregiving.

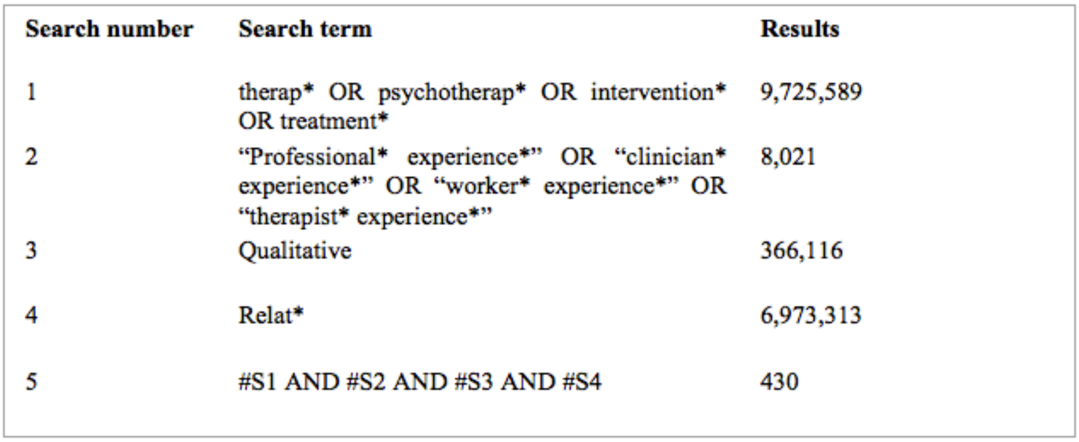
Wright et al (2015) performed a meta-analysis concerning the effectiveness of interventions in reducing disorganized attachment patterns revealing a highly significant benefit for intervention groups compared to controls (Odds Ratio: 0.47, 95% Confidence Intervals 0.34 -0.65, $p < 0.00001$). Regarding treatment length, interventions of less than five sessions were not statistically significant. Interventions with durations of five-16 sessions and 16 sessions or over were both significant, and the effect size was no greater when sessions were above 16 than when they were between five and 16. However, few studies examined interventions of less than 5 or over 16 sessions such that definitive conclusions about treatment duration were not possible (Wright et al, 2015). Regarding child age, the largest effect sizes were for children aged six-months or older however this may be a function of the time needed to identify children at risk, the age criteria of assessments for disorganized attachment and the few included interventions concerning the early perinatal period. Interventions both with and without male caregiver involvement demonstrated significant effect sizes, as did intervention with and without video-feedback. The majority of interventions included a component addressing maternal sensitivity for which effect sizes were highly significant. Two supplementary reviews were conducted concerning assessment of attachment patterns and disorders, and intervention cost-effectiveness. Regarding the former a major issue identified was the variability in classification procedures between studies with implications for the communicative and construct validity of attachment phenomena. Regarding cost-effectiveness evidence was inconclusive with Wright et al (2015) considering that the benefits of attachment-based interventions may be accrued in later years but that the lack of long-term follow-ups precluded information on this.

The issues raised in the review by Wright et al (2015) regarding treatment duration, key targets for intervention and age of infant at implementation have been raised elsewhere in the literature. Regarding the ‘less is more’ effect of treatment duration (Juffer et al, 2014), there is evidence to the contrary (Ziv, 2005) and in contexts of high risk and parental mental health interventions may require longer duration (Wright et al, 2015). Although Wright et al’s (2015) review demonstrated larger effect sizes for interventions with infants aged six-months or over, a study by Heinicke et al (2000) with at risk and socially marginalized mothers indicated that intervening prior to six-months established a positive foundation from which differential changes were only evident during the seven to 12-month period. There may be sleeper effect (Barlow et al, 2010) in which the benefits of intervening earlier in the perinatal period take time to manifest. Although Wright et al (2015) found no evidence of a differential effect with interventions including fathers or not, a meta-data-analysis by Knudson-Martin and Silverstein (2009) emphasized the importance of mother's partners and the couple relationship in perpetuating and remediating PND, with indirect implications for the wellbeing of the infant. The review by Wright et al (2015) is limited in its ability to consider the impact of the interventions on parental wellbeing by focusing on child outcomes. Indeed, the reviews' focus solely on child outcomes is reminiscent of the child-focused orientation of services in which children are decontextualized from their family and society and attention is primarily given to promotion of positive developmental outcomes (Hood, 2015).

The outcome literature is predominantly oriented towards pre and post quantitative measures of change, with a lack of contextual secondary outcomes (Wright et al, 2015). There are paradoxical findings regarding the duration of interventions, and unclear understandings of the extent to which parental representations or parental behaviours or both should be targeted, with maternal sensitivity itself described by Holmes (2014) as a mysterious capacity. In the context attachment theory, and particularly Crittenden's (2005) DMM, the intervention needs of one person (for example with a Type A strategy) may be the converse of another (with a Type C strategy). This could have implications for the direction of effect of treatment captured by outcome measures, which could be masked by averaging across samples. Furthermore, research relying on the measurement of regularities does not in itself provide information on the mechanisms of change at work. Qualitative research can provide such information (Easton, 2010). Particularly in the context of attachment and RF theory, the clinician's role in the process of change is indicated and consultation to their experiences may be illuminating in considering paradoxical and summative findings such as those above. Indeed, Norcross and Wampold (2011) state that in light of evidence that the therapeutic relationship accounts for the successes and failures of treatments at least as much as particular techniques and methods, research on best practice and evidence-based practice is misleading and incomplete where it does not consider the therapeutic relationship.

## 1.8 Systematic review

A systematic search and narrative review was conducted to examine and critique literature exploring therapists' relational experiences of their work with clients in order to consider how their perspectives contribute to understanding the process of change in psychotherapy not captured by outcome research using quantitative methods. Preliminary searches for studies focusing on the perinatal period and/or using an attachment or RF frame yielded very few results. The search was therefore expanded to consider therapy broadly. A search strategy identified relevant papers for screening using eligibility criteria. The following databases were searched simultaneously using EBSCOhost on the 13th April 2016: MEDLINE with full text; CINAHL Complete; PsycARTICLES; PsychINFO. Date restrictions were not used; searches ran between preset database publication dates (1995-2016). A limit was set in order to retrieve research available in the English language. All included studies were published in peer-reviewed journals to maximize methodological quality. Figure 1.2 summarizes the strategy, search terms, and results.



| Search number | Search term | Results |
|---|---|---|
| 1 | therap* OR psychotherap* OR intervention* OR treatment* | 9,725,589 |
| 2 | "Professional* experience*" OR "clinician* experience*" OR "worker* experience*" OR "therapist* experience*" | 8,021 |
| 3 | Qualitative | 366,116 |
| 4 | Relat* | 6,973,313 |
| 5 | #S1 AND #S2 AND #S3 AND #S4 | 430 |

*Figure 1.2*: Search strategy

An additional search on 13th April 2016 using the Google scholar search engine and search terms 'clinician experience therapy qualitative' yielded a further two studies providing 432 studies for screening.

### 1.8.1 Screening and eligibility criteria.

The 432 results were screened by abstract review, applying the following inclusion and exclusion criteria. Inclusion criteria: qualitative studies investigating professionals' relational experiences with clients in therapy. Exclusion criteria eliminated studies focusing on: physical health; inter-professional relationships; treatment allocation and decision-making; therapists' personal lives; project implementation; use of specific techniques. Figure 1.3 displays the screening process, with 424 articles screened out and eight screened in.

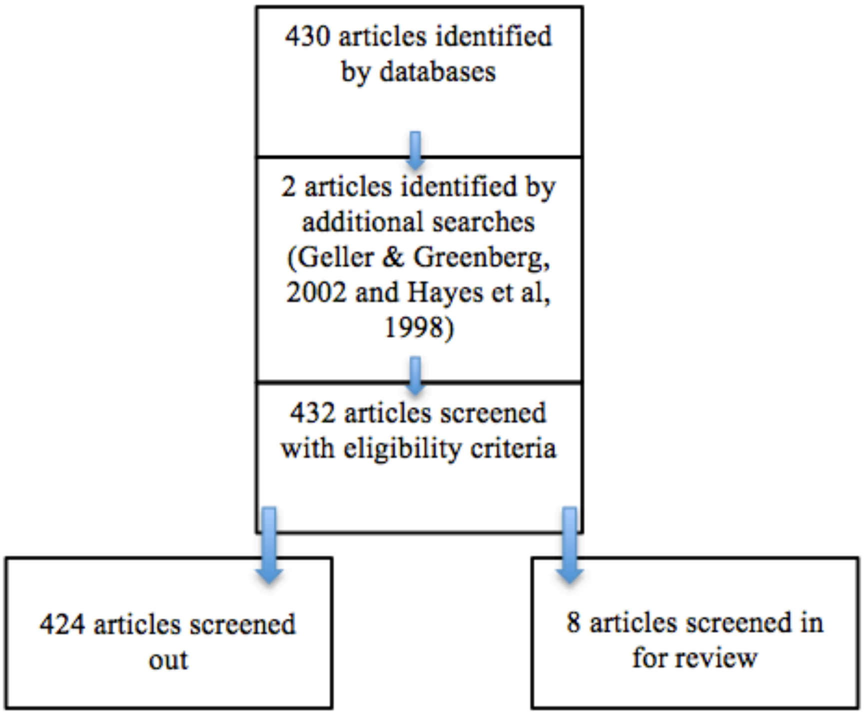


*Figure 1.3*: Search summary and screening stages.

### 1.8.2 Results.

Table 1.1 summarizes the eight articles included for review. The studies were critiqued from a thematic perspective, rather than study-by-study, to enable synthesized comparisons.

Table 1.1 *Summary of reviewed articles*

| **Study** | **Country & therapist context** | **Sample** | **Aims** | **Method of inquiry** | **Analysis** | **Main findings** |
|---|---|---|---|---|---|---|
| Carrick (2014) | UK, multiple settings | 10 female experienced person-centred therapists | To explore therapists' experiences and work with clients at points of crisis. | 1:1 Semi-structured interview | Person-centred/ phenomenological framework using McLeod's (2003) five stages of analysis | Therapists' experience a polarity between danger and opportunity with clients who appear both vulnerable and open in crisis; 'relational depth' and symbolization of clients' experiences can foster change and growth. |
| Cooper (2005) | UK, therapist service context not reported | 7 Person-centred and 1 solution-focused therapists (5 women, 3 men) | To explore therapists' experiences of meeting clients at 'relational depth'. | 1:1 Unstructured interviews | Person-centred, phenomenological framework. Steps of analysis detailed but not guided by a particular method. Use of Hill's (1997) conventions for reporting frequencies in the data. | Therapists' experience moments of 'relational depth' with clients characterized by high levels of empathy, acceptance and genuineness, feelings of aliveness, receptivity and satisfaction. Clients are experienced as in touch with core aspects of themselves and engaged in a 'co-presence' with the therapist. |
| Hayes, Nelson & Fauth (2015) | USA, two large cities and a college town on the West coast | 18 therapists, (10 men, 8 women) | To explore therapists' subjective experiences of CT in cases they judged to be successful and unsuccessful. | 1:1 Semi-structured interviews | Grounded theory | CT was evoked in successful and unsuccessful cases alike, triggered by unresolved personal and professional issues activated by perceptions of clients. Successful and unsuccessful cases differed in specificity, quality and management of CT. In successful cases therapists differentially described efforts to reframe, decenter, and depersonalize to manage CT. |

| Study | Country & therapist context | Sample | Aims | Method of inquiry | Analysis | Main findings |
|---|---|---|---|---|---|---|
| Hunter (2012) | Australia, 5 general counseling agencies in a large city | 8 couple and family therapists (7 women, 1 man) | To explore therapists' perceptions of satisfaction and risk in the therapeutic bond and understand how qualities of the therapeutic bond may relate to vicarious traumatization and personal growth of therapists. | 1:1 interviews | Grounded theory | Therapists' value the therapeutic bond, which requires client investment and mutual affirmation. The therapeutic bond provides both satisfaction and risks for therapists particularly in contexts of client trauma and over-identification. Therapists reported growth above vicarious trauma through encounters with clients. |
| Lorem & Hem (2012) | Norway, multiple settings (acute wards, outpatient and rehabilitation clinics, shared-house projects) | 11 mental health care professionals (nurses, psychiatrist, psychologists) | To explore therapists' perceptions and approaches to working with patients experiencing psychosis. | 1:1 interviews | Narrative methods and thematic analysis | Analysis produced three themes: maintaining expectation of meaning in the context of not yet understanding is crucial to the relationship; understanding is created through emotional contact (verbal and non-verbal); meaning and understanding of clients' experiences is found via personal identification, normalization of suffering and time. |
| Mayer, White, Ward & Barnaby (2002) | USA, early intervention services for children with disabilities | 9 occupational therapists | To gain understanding of therapists' experiences of making what they perceived as real differences to parent-child relationships. | 1:1 interviews | Phenomenological framework with analysis steps outlined and use of code-recode strategy (Lincoln & Guba, 1985) | Therapists reported valuing the parent and child and the need to show this; teaching parents to interpret children's distress cues was key; a shift in practice over time/experience from an 'expert' to collaborative position; the mutually influential nature of therapist-parent and parent-child relationships, and child development. |

| Study | Country & therapist context | Sample | Aims | Method of inquiry | Analysis | Main findings |
|---|---|---|---|---|---|---|
| Moltu & Binder (2014) | Norway; five therapy training institutes | 12 experienced supervising therapists across therapeutic orientations (6 men, 6 women) | To explore how therapists across orientations experience their contribution to change in difficult but constructive cases, and how they relate to their specific modality in the process. | 1:1 semi-structured interviews as a basis for phenomenological exploration | Hermeneutic phenomenological epistemology using an exploratory-reflexive thematic analysis. | Therapists' experience their contribution to difficult therapies as maintaining a double awareness (of perspective and closeness) to create relational space using three main activities: tailoring the frame to clients' relational vulnerability; using embodied experiences to become emotionally close; creating meaning using theoretical perspectives. |
| Geller & Greenberg (2002) | Canada, therapy practice settings | 7 therapists who were proponents or authors on therapeutic presence | To identify and explore therapists' experience of presence in psychotherapeutic encounters and develop a model of therapeutic presence. | 1:1 interviews | Integrative analysis combining condensation and categorization of meaning using Kvale's (1996) five-step process | A model was developed revealing three essential aspects of presence: preparation (prior to sessions, using intention and bracketing preconceptions, and in life through self-care and commitment to presence), process (receptivity, inwardly attending, balancing perspective and contact) and experience of presence (immersion, expansion, grounding, being with and for the client). |

CT = Countertransference; 1:1 = one-to-one interviews involving a researcher and participant

#### *1.8.2.1 Methodological critique.*

Researcher reflexivity and potential influence was acknowledged in five of the studies (Carrick, 2014; Cooper, 2005; Hayes, Neslon & Fauth, 2015; Hunter, 2012; Moltu & Binder, 2014). Carrick (2014) and Cooper (2005) in particular acknowledge their person-centred practice and interest in the research phenomena, with Carrick (2014) undergoing an interview as a participant to explicate these. However, it is notable that in both these cases the expectations and experiences of the researchers with the phenomena under study (both attending to relational depth) were closely confirmed by the research. Similarly, Cooper (2005), Carrick (2014) and Geller and Greenberg (2002) all provided participants with detailed definitions of the relational phenomena of interest, seemingly performing confirmatory rather than exploratory inquires. Participants in Mayer, White, Ward & Barnaby (2002) study were provided with the researcher's own experiences of making a 'real difference' to parent-child relationships if deemed necessary to stimulate dialogue. Mayer et al (2002) also report only 'some stories' were selected for analysis without recourse to these decisions. The researcher's use of examples could have influenced participants' responses, which alongside the selective data analysis could culminate in a highly researcher-led process. Hayes et al (2015), Mayer et al (2002), and Moltu and Binder (2014) asked participants to consider clients and experiences to discuss, such that in the majority of studies participants had prepared for the discussion topic. This stands in contrast somewhat to attachment and RF informed interviews, such as the AAI and PDI, which emphasize a level of surprise in the questions to promote fresh thinking and as a measure of discourse coherence when unprepared.

Alongside researcher interests, recruitment procedures across the studies may also have had consequences for the extent to which studies seemed biased by circular reasoning. Exemplified by Cooper (2005), participants were recruited on a basis of having experienced relational depth, were provided with a definition of it, interviewed regarding their experiences of it, which informed a conclusion that participants described relational depth consistently with the definition. With the exception of Mayer et al (2002) who required participants with three years' experience working with parents and infants minimum, all studies recruited highly 'experienced' or 'skilled' participants. Recruitment procedures were generally minimally reported. Cooper

(2005) and Hayes et al (2015) recruited colleagues and professional contacts, and Carrick's (2014) sample was acquired through snowballing based on previous participants. Geller and Greenberg (2002) identified authors or proponents of the phenomena of interest, 'therapeutic presence', without providing information on this process. In these cases, participants and researchers alike appeared formerly aligned with the phenomena of interest. Although not at odds with a qualitative inquiry, this has implications for the transferability of findings to other contexts and professionals whereby samples and researchers may represent a specialist, demarcated group.

Four of the studies made inquiries that tended towards positive experiences in therapy. Cooper (2005) and Geller and Greenberg (2002), by virtue of the research phenomena (relational depth and presence, respectively), attended to moments of heightened therapist-client connection. Mayer et al (2002) and Moltu and Binder (2014) considered how constructive change arises. Although the other studies did not centre on positive experiences specifically, only Hayes et al (2015) inquired about experiences within cases deemed unsuccessful. Although a strength of qualitative research is providing nuanced explorations of phenomena, the conclusions of the studies predominantly endorsed positively framed premises. Alongside the use of researchers and participants aligned with phenomena, this seems reminiscent of issues in wider psychological research whereby null findings or negative experiences are sidelined by the research process.

Steps of analyses were outlined across the studies, although the conventions followed varied particularly in those not using a demarcated approach such as grounded theory or thematic analysis. Moltu and Binder (2014) was the only study to explicitly refer to the epistemological position of the research. Similarly, this was the sole study to include examples of the stages of analysis and theme development. All studies bar Lorem and Hem (2012) referenced some form of reliability checking, with the majority using multiple researchers for this purpose. Only the primary researchers analyzed the data in Carrick (2014) and Cooper (2005) however participants checked transcripts and in Cooper (2005) reviewed the initial write up. Reporting of the results and use of illustrations varied. Hayes et al (2015), Hunter (2012), Mayer et al (2002) and Moltu and Binder (2014) used contextualized passages of quotes and reported on the commonality of themes across the set. In Cooper (2005), Carrick (2014) and Geller and

Greenberg (2002) narrative descriptions of the results seemed at the expense of illustrations, with the latter study not referencing quotes to specified participants, potentially impacting on the accountability of the data. Lorem and Hem (2012) relied heavily on the use of quotes from one participant.

Only three studies (Carrick [2014], Lorem and Hem [2012], Moltu and Binder [2014]) provided ethical considerations, with two further studies reporting ethical approval was obtained (Cooper [2005], Mayer et al [2002]). This raises questions for the extent to which care professionals are provided with the same safeguards and thought due all research participants, particularly in the context of research exploring their relational experiences with clients, which albeit within a professional arena, is by definition personally affecting.

#### *1.8.2.2 Key findings.*

The studies can broadly be grouped into those focusing on the experience of the relationship and those considering how the relationship dynamics contribute to change. Regarding the former, Cooper (2005) describes moments of relational depth whereby clinicians experience heightened perceptual clarity, immersion and empathy for the totality of the client. Through a feeling of congruence, clinicians felt able at these times to be spontaneous, and safe to be affected personally by clients. Clients were perceived as transparent and real, and through the relationship clinicians described a sense of co-presence and mutual acknowledgement, which Cooper (2005) describes as the therapist and client experiencing the Rogerian core conditions (such as unconditional positive regard, empathy and congruence) towards each other. Similarly, Geller and Greenberg's (2002) findings indicated overlaps between the concepts of relational depth, and presence. Themes described immersion, perceptual expansion and a grounding in the moment through which clinicians felt trusting and in respect of clients. Geller and Greenberg (2002) describe the necessity of a dual level of consciousness for presence involving an ability to shift between internal and external sources of information, from self to other, and from openness to responsivity. Moltu and Binder's (2014) findings also emphasized a dual awareness whereby therapists needed to simultaneously maintain, as opposed to shift between as with Geller and Greenberg (2002), both wider perspective and emotional closeness to the client. Through this a relational space is created supported by adapting the frame to the unique vulnerabilities of the client, paying attention to embodied emotionality and sharing theoretically informed understandings. Carrick's (2014) findings describe a similar process whereby relational depth required pacing, grounding and awareness of embodied sensations, through which therapists acted not to alleviate symptoms but to symbolize and make meaning out of clients experiences.

The dual awareness and ability to shift between an emotional connectedness and wider associations is also reminiscent of the efforts that clinicians in Hayes et al's (2015) study described. Clinicians reporting on successful cases differentially described managing countertransference, which may be understood as an emotional connectedness, by decentering and depersonalizing thereby actively re-focusing to a wider perspective. In managing work with traumatized clients, Hunter (2012) emphasizes the reciprocity of the therapist-client relationship. Findings indicated the importance of conveying empathy towards clients, and that through client investment and mutual affirmation therapists themselves felt validated and respected by clients. Although clinicians described feeling inadequate at times and more aware of dangers in life through the work, the reciprocal affirmation with clients contributed to satisfaction and experiences of vicarious resilience.

Regarding making a difference to parent-child relationships, Mayer et al (2014) highlighted shifts over time in therapists' practice, moving away from expert positions to a client-led approach, and becoming more confident to bracket specific therapeutic skills in order to attend to both their relationship with the parent and the parent-child relationship. Sharing understanding and learning to interpret children's cues from a supportive and positive position was key to making a difference, and many participants reported readjusting their expectations of parents through having had their own children. Personal identification was also underscored by Lorem and Hem (2012) whereby this, alongside time and normalization, helped to create meaning and understanding of clients experiences of psychosis. Crucial to the formation of a relationship with clients from which change could begin, Lorem and Hem (2012) emphasized the importance of maintaining an expectation of meaning in clients' communications particularly where these were not yet consciously understood.

### 1.8.3 Discussion and conclusion.

The eight studies reviewed provide a predominantly phenomenological understanding of the therapeutic relationship and process, that compliments research concerned with the efficacy of specific techniques and interventions. Indeed, as Motlu and Binder (2014) state such an understanding provides points of convergence across therapeutic approaches, again standing in contrast to prevailing intervention efficacy research that pitches approaches against one another.

The studies highlight a reciprocity in the therapeutic relationship that although may be alluded to within descriptions of relational and attachment based interventions, is not delineated by intervention efficacy research in way that can guide clinical practice. The reciprocity described by the included studies provides insights into the impact on the therapists both in terms of their moment-to-moment embodied emotional and perceptual experiences and in terms of the affirmation, validation and satisfaction they experience as receiving from clients. Although perhaps a function of the search for relational experiences of clinicians in therapy, talk of symptom-based change was noticeably absent across the studies. Instead, emphasis was placed on symbolizing and making meaning of clients experiences to enable change.

The studies drew upon a range of theoretical understandings to frame their findings including the work of Carl Roger's (1951, 1957) on client-centred therapy and the 'core conditions', Orlinsky and Howard's (1987) conceptualization of the therapeutic bond, Hayes' (1995) model of countertransference, and relational depth (Mearns, 1997). The findings of the studies may also be interpreted within an attachment and RF frame. The grounding, felt-safety and trust that could enable therapists to be spontaneous as described by Cooper (2005) and Geller and Greenberg (2002) is reminiscent of the establishment of a secure base from which therapists and clients may explore the clients' associations. Therapists ability to shift attention between the self and other, and internal and external sources of information as described by Geller and Greenberg (2002) likewise parallels two of the dimensions of mentalization as described by Fonagy and Luyten (2009). Similarly, the ability to maintain and use a dual awareness to remain emotionally connected to clients whilst being conscious of wider perspectives described by Motlu and Binder (2014) and operationalized by clinicians in Hayes et al's (2015) study who managed affecting experiences through decentering, may be framed as the ability to think and feel at once, a tenet of integrated mentalizing. Lorem and Hem's (2012) emphasis on maintaining an expectation of meaning is further congruent with a mentalizing stance whereby there is an appreciation of the opacity of mental states coupled with a commitment to the intentionality of others' communications. Although it is possible to infer these parallels, qualitative research investigating clinicians' relational experiences from an attachment and RF viewpoint is lacking and would be informative in delineating and complementing the intervention efficacy research in this area.

The methodological critique raises issues concerning the extent to which researcher and participant affiliations, provision of phenomena definitions and a tendency across studies to focus on positive moments of connection in therapy sideline other, particularly negative, experiences, and confirm rather than explore the areas of interest. Although Hayes et al (2015) investigated successful and unsuccessful cases this was in relation to countertransference specifically. An inquiry that addressed both positive and negative relational experiences in therapy in relation to change processes would expand understanding of possible relational factors at play when therapy challenges and the impact upon therapists in these moments. In relation to this, the studies which investigated therapist experiences within the context of particular client outcomes (Moltu and Binder [2014], Mayer et al [2002], Hayes et al [2015]) were based solely on the clinicians' judgement of the cases as, for example, successful. Indeed, Moltu and Binder (2014) call for the use of quantitative outcome measures to complement and contextualize therapists' descriptions of the therapeutic process. Lastly, the review highlights the use of expert or highly skilled therapists across the studies. Particularly in the current context of the NHS wherein newly qualified and less experienced clinicians may have greater client contact as more experienced personnel occupy management and supervisory roles, an inquiry incorporating multiple perspectives of a staff team across expertise may have greater relevance to day-to-day therapeutic encounters.

This review identified eight studies across a range of settings that provide a phenomenological understanding of therapy from clinicians' perspectives. The studies endorse the relationship as a valued and information-rich aspect of therapy from the viewpoint of clinicians. The methodological critique established areas to build upon in future research to complement both intervention efficacy research and experiential understandings of therapy and change.

## 1.9 Summary and study rationale

Literature highlights the perinatal period as a time of increased risk for both mothers and infants, particularly those who have additional psychological and social risk factors. Enquiry reports and research have established poor outcomes and service engagement for mothers from marginalized social contexts wherein mothers' relationships with services can be characterized by avoidance, distrust and silencing. Nuanced understandings of these relational processes in perinatal mental health contexts are lacking. The centrality of, and parallels between, the parent-infant and therapist-parent relationships as mechanisms of change have been supported by empirical research and theoretical writing on attachment and RF. Efficacy literature regarding attachment-informed interventions has endorsed approaches seeking to enhance maternal sensitivity in particular, and noted a predominance of multi-faceted interventions incorporating techniques to explore parental representations of their infants, provide positive feedback regarding parenting efforts and improve attachment. However, there is a dearth of contextual, secondary outcomes and inconclusive evidence regarding which aspects of the parent-child context should be targeted. Qualitative research can complement outcome literature by delineating the therapeutic relationship, which can be considered as much a contributor to change as specific interventions and techniques (Norcross and Wampold, 2011). The review of qualitative research exploring relational experiences of therapy from clinicians' perspectives highlights a need for further research to explore both positive and negative relational experiences in therapy across levels of expertise, consider the contributions of these to change, and contextualize these inquiries with reference to measures of outcomes for clients.

The current research seeks to address these issues by making a qualitative inquiry with a range of clinicians from different disciplines working within the PIMHS. The research intends to extend understanding of relational processes between clinicians and mothers in a perinatal mental health context through exploration of clinicians' reflections, with a focus on both positive and challenging moments and consideration to how these may influence change for the mothers and their infants. Furthermore, the research seeks to contextualize the inquiry by considering measures of change for the mothers and infants using pre and post-intervention outcomes. The contribution of this component intends to consider how these two research methods may describe alternative stories of therapeutic change.

## 1.10 Research aims

1) To explore the PIMHS clinicians' relational experiences with the mothers and infants they work with, and their reflections on therapeutic change
2) To analyze quantitative outcomes for the mothers and infants engaged with the PIMHS using pre and post-intervention measures

# 2. Methodology

## 2.1 Epistemological stance

Epistemology and ontology, referring to theories about the nature of knowledge and reality respectively (Braun & Clarke, 2013), are of critical importance to social scientific inquiry (Greene & Hall, 2010). The assumptions of these, in addition to researcher predispositions and context, influence the frame, design, implementation, and interpretation of empirical work (Greene, 2007). This chapter begins by outlining the epistemological stance taken in this thesis from which the methodology adopted is explained and justified.

### 2.1.1 Dominant positions.

Ontological positions vary along a continuum ranging from the perspective that a single reality exists independently of human practices, known as realism, to the perspective that there are multiple realities entirely dependent on human practices, known as relativism (Braun & Clarke, 2013). Linked to ontological positions are perspectives on what is possible 'to know', or epistemological positions. These can similarly be conceptualized along a continuum in which positivism, allied to realism, assumes an objective reality or truth can be known through application of scientific method, to constructionism, allied to relativism, in which context-dependent knowledges are socially created through discourses. Ontological and epistemological positions influence methodological frameworks and method selection (Braun & Clarke, 2013). Positivism and constructionism have traditionally employed quantitative and qualitative approaches, respectively.

Research and debates on psychopathology have been characterized by these two dominant and polarized positions (Pilgrim & Bentall, 1999). In the 1970s and 80s, the 'paradigm wars' saw academic debate regarding quantitative and qualitative paradigms and their philosophical underpinnings (Hall, 2013). The Humean philosophical assumption underlying mainstream quantitative research posits that regularity and causation can be established through variable-oriented experimentation and replication.

This assumption fundamentally relegates qualitative research (Maxwell & Mittapalli, 2010). Likewise, qualitative researchers associating with an ardent constructionism reject the quantitative tenet of verifiable knowledge about the world in terms of causation (Guba & Lincoln, 1989) and thereby renounce central aspects of quantitative methodology (Maxwell & Mittapalli, 2010). The implications of both positions and their traditionally associated methodologies may be seen as unsatisfactory. The positivist endeavor to discover regularities of events is not in itself a casual explanation but rather a context-removed atheoretical statement without insight as to why it is so (Easton, 2010). Constructionism does not make causational claims but rather seeks to problematize causal statements about mental health/illness (Pilgrim & Bentall, 1999). However, this has led to criticisms that for example radical constructionism does not acknowledge psychological, sociological and material risks as real (Houston, 2001). A third position continues to gain attention in the field of mental health research, which can be viewed as occupying a space between these polarized positions, most commonly referred to as critical realism (Pilgrim & Bentall, 1999).

### 2.1.2 Critical realism.

Critical realism has been described as incorporating a realist ontology and a constructionist epistemology (Easton, 2010; Maxwell & Mittapalli, 2010) whereby a reality exists independently of human interpretation but our understanding of this reality is constructed based on our perspectives and is therefore not fully apprehensible (McEvoy & Richards, 2006). It often incorporates an emancipatory axiology (Easton, 2010), which is dependent on the presupposition of causation as for the concepts of change, agency and responsibility to be meaningful, discourses must be performative and thereby causal (Sayer, 2004; Bhaksar, 1989).

Although critical realism attests to the constructional nature of knowledge as mediated through discourses, it maintains that we receive a feedback from the world. For example, iterative processes of what has been constructed are re-construed by others, through which we experience the fallibility of our knowledge (Sayer, 2004). It views the world as differentiated and stratified whereby certain phenomena are emergent from constituent events and in turn give rise to the development of other stratums of emergent phenomena. For example, biological processes emerge from chemical and physical processes, and give rise to social and cultural processes (Sayer, 2004). Emergent phenomena may be irreducible to their constituent objects. Phenomena should be studied at their own level as higher strata phenomena can react down upon lower strata objects, but interactions occur through processes at the level of stratum being changed. Higher strata processes are dependent on lower strata phenomena but not vice versa. Reality is a set of related strata in which events arise through a plurality of partial regularities and processes (Downward, Finch & Ramsay, 2002). This complex co-determination means that causes of events may only be revealed partially. Critical realism allows an acknowledgement of the complexity of social phenomena but upholds that explanation is a valid goal for social scientific research (Hall, 2013). Causal mechanisms may be inferred through empirical investigation and theory construction with the goal of research being to extend levels of explanation and understanding rather than identify generalizable laws or lived experiences of social actors as per positivism and constructionism, respectively (McEvoy & Richards, 2006).

### 2.1.3 Mixed methods research and critical realism.

The distributions, frequencies and regularities of phenomena can be helpful in making observations, with quantitative methods identifying patterns and associations that might otherwise remain hidden (McEvoy & Richards, 2006). However, causal explanations are likely to also need qualitative descriptions of causal powers to allow retroduction (Sayer, 2004), which seeks to establish mechanisms capable of producing events (Easton, 2010). Critical realists view that both qualitative and quantitative inquiries are necessary in social science. It is thereby a compatible philosophical stance for research incorporating these two methods.

The rationale for using both qualitative and quantitative inquiries is often triangulation. Triangulation is commonly employed for three reasons: confirmation (whereby using both approaches may counteract biases associated with each and provide corroboration); completeness (triangulation allows a deeper understanding of a phenomena obtained via different perspectives); and retroduction (McEvoy & Richards, 2006). Research using mixed methods can allow a dialogue between different perspectives of phenomena under study and the different lenses required may produce generative insights and deeper understanding (Greene & Hall, 2010).

The description of qualitative and quantitative approaches as using different lenses is incorporated into the rejection of mixed methods research known as ‘the incompatibility thesis’. This states that qualitative and quantitative research is associated with distinct and incompatible paradigms and world views (Robson, 2011; Masse, 2000). However, many mixed methods researchers reject this thesis on the basis that methods should be combined according to practical utility, and disagree that methods are intrinsically linked to philosophical positions (Maxwell & Mittapalli, 2010). Furthermore, distinctions between qualitative and quantitative research may be less discreet in practice, for example dichotomies suggesting one is focused on meaning versus behaviour, or that one uses inductive versus hypothetico-deductive logic (Brannen, 2005). This stance is associated with pragmatism, which advocates bracketing philosophical issues in research (Robson, 2011). However, pragmatism is criticized on the grounds that it underestimates the inherent ontological, epistemological and axiological assumptions that influence researchers’ values and actions (Maxwell & Mittapalli, 2010).

### 2.1.4 Rationale for critical realism in the current research.

The current research seeks to explore PIMHS clinicians’ relational experiences of their work using a qualitative approach; and analyze outcome measures for the parents and infants engaged with the PIMHS using a quantitative approach. Sayer (2000) makes distinctions between extensive and intensive forms of research. The former encompasses use of questionnaires and statistical analyses to establish patterns but has little explanatory power. The latter uses interviews and qualitative analyses with individuals in context to ask what produces change and derive explanations and further hypotheses (Easton, 2010). Extensive methods do not necessarily require large sample sizes, which may also employ intensive methods. Accordingly, both of the current research inquiries are compatible with a critical realist position.

From a critical realist perspective, practice-based research does not seek to answer whether or not programmes or services ‘work’ but rather what do service resources offer that enable people to make them work (Pawson & Tilley, 2008). This perspective fits with the current researches’ aim of interviewing clinicians to deepen understanding of their working, relational context with parents and infants and what enables or hinders change. A critical realist perspective that agents and structures are constitutive of each other and that human agency should be explored in its institutional context (Downward et al, 2002) can be usefully applied to the real-world context of the current research, considered an ‘open-system’ (Robson, 2011). Furthermore, critical realism is appealing in real world research where complex health care systems and interventions are not easily reducible to describable entities, as a positivist position may demand, but where there are nonetheless requirements for ‘real’ quantifiable outcomes rather than perceptions of interaction with a system (Byng, 2002). Critical realism’s account of the role of both agents’ meaning making and structural factors as impacting on one another, also aligns with the researcher’s own beliefs, as well as the practice of the PIMHS which considers the parents and infants meaning making and wider systemic structures impacting upon their relationship. Lastly, research findings that ‘lay’ people naturally integrate and make use of both structural and agent related casual attributions of mental health and illness, suggest research inquiry should be concerned with and acknowledge both real material conditions and the human constructions situated within these (Pilgrim & Rogers, 1997).

## 2.2 Design

A principle of research design should be that the questions and aims posed determine the methods selected, rather than vice versa (Bamberger, Rao & Woolcock, 2010). The aims of the current research were to explore clinicians’ relational experiences of their work in the PIMHS project and to contextualize the inquiry with outcomes for the parents and infants supported by the PIMHS.

With regards to the first aim, although research literature indicates that clinicians’ relational experience of their work with parents and infants may be a significant mechanism of change (Slade, 2007; Cologon, 2013), research exploring relational processes in perinatal mental health settings from clinicians’ perspectives is lacking.

This aspect of the research was exploratory, seeking to deepen understanding and contextualize the relational processes of the work. Qualitative research is appropriate for this aim as it can capture the complexity and contradiction of real world settings whilst allowing patterns of meaning to be produced (Braun & Clarke, 2013). It is further a suitable approach for under-research areas.

Operational questions and understanding are important in real world research concerned with new service projects, in addition to more typical questions regarding treatment implications for the wellbeing of service users (Bamberger, Rao & Woolcock, 2010). Projects are invariably not implemented as planned (Mosse, 2005). Qualitative research with key informants provides contextual information on project processes, allowing insights regarding how the operationalization of a service may have impacted on achieving its aims. Furthermore, the complex and multidimensional nature of constructs such as wellbeing and risk has consequences for the construct validity of quantitative measurements of these within services (Bamberger et al 2010). Qualitative approaches can help understand the meaning of quantitative indicators. Conducting a qualitative inquiry therefore fits with the aim of developing a contextualized understanding of the PIMHS working processes, and as a complimentary form of triangulation that adds rigour to the research.

From a critical realist perspective, the key strength of qualitative methods is that they are open-ended allowing themes to emerge during an inquiry that could not have been anticipated or would be unlikely to be captured by predefined or standardized measures (McEvoy & Richards, 2006). Semi-structured interviews provide flexibility to explore alternative lines of inquiry regarding phenomena of interest within the bounds of a particular research area (Miles & Gilbert, 2005). Potential explanations can emerge through conversational interviews, as the interviewer is not bound to predetermined measurement of variables (McEvoy & Richards, 2006) allowing the interviewee to raise aspects of the topic that they consider important. The tacit knowledge and clinical intuition that often guides therapeutic practice and is gained through experience (Malterud, 2001) is best studied through qualitative means such as semi-structured interviews (Silverstein, Auerback & Levant, 2006). Semi-structured interviews were thereby considered a suitable method to explore the PIMHS clinicians' relational experiences of their work.

In considering the second aim, the PIMHS project was conducted within a particular political and financial time whereby services are required by commissioners to demonstrate quantifiable changes for the people they support. Measures of outcome should be incorporated into psychological therapies service as a matter of routine (DoH, 2009) including perinatal mental health services (NICE, cg192, 2014). Analyzing change at the level of individual clients and services may reduce the distance between research and practice-based evidence (Mullin, Narkham, Mothersole, Bewick & Kinder, 2006). Evidence from research trials can show statistically significant differences from pre to post therapy via a small degree of change on outcome measures, provided most clients experienced this change. However, such a small amount of change may not be meaningful at the level of individual clients and practitioners (Mullin et al, 2006). The PIMHS pilot supported a small number of parents and infants. The small sample size thus precluded the use of statistical analyses based on group averages. A quantitative component providing pre- and post-intervention comparisons of scores on standardized measures was deemed important in allowing insight into individuals' profiles of change to contextualize the qualitative inquiry and explore stories of change in the PIMHS context reflective of current practice requirements.

From the mid 1980s, Jacobson and colleagues (Jacobson, Follette & Revenstorf, 1984; Jacobson & Truax, 1991) conceptualized and developed procedures for determining therapeutic change based on criteria of clinical and reliable, rather than statistical, significance. The procedures address two main questions: firstly, is the amount of change shown by a client on a measure of sufficient magnitude that it is unlikely to have occurred by chance or measurement error alone, that is, is it reliable; and secondly, has the client's score moved sufficiently that it falls within the range expected in the general population rather than the clinical population, that is, can the change in scores be considered clinically meaningful. In addressing these two questions, the procedures establish whether a client's pre-post therapy scores on a measure constitute reliable and clinically significant change. This practice-based tool allows a bridge between research and practice (Mullin et al, 2006), is growing in popularity, and is an appropriate method of establishing the clinical relevance of individual change during therapy (Ogles, Lunnen & Bonesteel, 2001). It was therefore considered an appropriate method to examine the extent of change on the pre and post intervention outcome measures completed by the parents involved with the PIMHS. The procedures for conducting reliable and clinically significant change calculations are outlined in a subsequent section of the chapter.

Although Randomized Controlled Trials (RCTs) continue to be upheld as the ‘gold standard’ of research methods in health sciences, critiques of this approach have risen over the past 20 years (Song, Sandelowski & Happ, 2010). A selection of these include: that they are rarely implemented according to textbook standards, softening the distinction between RCTs and other research modes in practice; that their distinctive feature of control and standardization of inherently complex health and social phenomena poses a threat to internal validity; as an extension of this latter point that they are thereby susceptible to threats of external validity as they may not generalize to the uncontrolled real world of practice; and that they are at ethical odds with the values of person-centered care and rights to choose embedded in our current care system (Song et al, 2010). In addition to these concerns, method selection to address the research aims needed to be practical and feasible, in keeping with pragmatic parameters of the PIMHS, the doctoral thesis context and acceptable to those who might use the findings. The researcher sought to inquire about stories of change within the real world context of the PIMHS, and did not have control over the parent and infant sample, interventions or measures used by the PIMHS for routine outcome monitoring.

The current research thereby employed a qualitative inquiry using semi-structured interviews, contextualized with a small n, quantitative analysis of outcomes for the parents and infants. The qualitative method (semi-structured interviews) was used to explore and contextualize the relational processes of the PIMHS work from clinicians’ perspectives at one time point during the closing stages of the PIMHS interventions. The quantitative method (clinically significant and reliable change) was used to examine changes in outcome measures using two (pre and post) intervention time points. The quantitative component was conceptualized as taking a secondary priority to the qualitative component (Morgan, 1998) and as an illustration of the PIMHS working context providing a complementary method of triangulation (McEvoy & Richards, 2006).

## 2.3 The PIMHS setting

Commissioners in the East of England funded the establishment of the PIMHS based at a children's centre in a seaside town with a high level of social deprivation and higher than national average levels of care protection proceedings. The service was jointly commissioned by local NHS Foundation Trusts and partner agencies in order to benefit from an interagency and interdisciplinary approach to mental health provision. The PIMHS is supported by clinicians from Child and Adolescent Mental Health Services (CAMHS), Adult Mental Health Services (AMS), children's centre staff and social services. The composition of staff includes two psychiatrists, adult psychotherapists, a psychologist, a specialist midwife, social workers and a social work manager, mental health nurses and practitioners, and family support workers from the children's centre.

The service was commissioned to pilot the assessment and treatment of five plus parent and infant dyads deemed high risk with the overarching aim of the infants remaining with their families rather than being taken into state care. The focus was thereby on early intervention in targeting support towards parents and infants to safeguard healthy infant development and thereby reduce later costs linked to mental health difficulties, anti-social behaviour and care proceedings. In order to achieve this aim, the PIMHS focused its' interventions towards the parent – infant relationship and the mental health needs of parents to facilitate the development of healthy infant attachment strategies and healthy parental functioning and mental health. In the event of an infant needing to be removed from the family, the PIMHS planned to formulate further therapeutic input with a view to supporting on-going parental mental health needs either within the context of established PIMHS interventions if appropriate or through referrals to universal services.

To meet these ends, the outline of the service was set up as follows: assessment of the parent – infant relationship to identify areas of strength and need; assessment of parental mental health; allocation of a care co-ordinator, mental health support and treatment through CAMHS and/or AMS; initial therapeutic interventions consisting of six sessions through which to determine the likely timescale for change as required by the dyads; further psychotherapeutic work if indicated up to a year with reviews following phases of six sessions; continuation of existent mental health input from interagency staff alongside that provided by PIMHS; regular interdisciplinary case discussions promoting cohesive work with reports contributed from each professional allocated to the case. The rationale for the centrality of interdisciplinary and joined up working embedded within the service was to facilitate the broadening of professional perspectives, reflectivity and shared understanding between involved referrers and clinicians through regular collective case discussions and reviews. As a multi-agency, multi-disciplinary group of professionals working across the locality, the children's centre acted as a base for the collective, housing regular case discussions and promoting a community presence for the PIMHS.

## 2.4 Participants & sampling

### 2.4.1 Clinician participants.

Clinicians working as part of the PIMHS were approached to participate in the qualitative component of the current research. Clinicians across professional disciplines were approach, as together they were considered information rich (Byng, 2002) and capable of identifying important issues relevant to the holistic working processes of the PIMHS. The inclusion criteria were to be involved in professional work within the PIMHS and consent to engage in the current research. Exclusion criteria were not deemed necessary as the researcher sought to maximize the contributing perspectives under the banner of the PIMHS working context. Ten clinicians were recruited, spanning professional disciplines and roles within the PIMHS. Their basic, non-identifying demographics are presented in the following chapter.

#### 2.4.1.1 Clinician recruitment procedures.

The consultant psychiatrist of the PIMHS facilitated the researcher's contact with the team. Through this communication, the researcher verbally presented the research purposes and processes, and distributed 'Expression of Interest' forms (EOIs; Appendix A) and information sheets (Appendix B) to the PIMHS team during team meetings in summer 2015. EOIs were collected at subsequent team meetings and provided the researcher with initial permission to contact potential clinician participants at preferable times to discuss taking part. All clinicians who completed EOIs were willing to participate. Dates and times to participate were arranged by phone or email according to the participants' preference.

The recruitment of clinician participants was opportunistic and dependent on willingness to take part. Although a pragmatic and ethical approach, it is acknowledged that this may have introduced sample bias and that clinicians experiencing difficulties within the PIMHS may have been less forth coming towards participating. However, in attempt to minimize this it was made explicit in verbal presentations of the research and in information sheets that the aim was to incorporate varied perspectives of the PIMH team.

### 2.4.2 Parent and infant dyads.

The PIMHS aims to support families and women in the perinatal period deemed high risk and in contact with children's services. Target groups included those where mental health difficulties, substance and alcohol abuse, domestic violence and abuse, unresolved trauma and loss, learning difficulties and eating disorders were implicated. Referrals to the PIMHS came either from children's center staff or social services. The criteria for referral were as follows:

1. Parent with infants aged between 0-2 years
2. Involvement of children's services under section 17 or 47 such that all infants would be subject to a Child In Need or Safeguarding plan
3. Active involvement of a health visitor or General Practitioner (GP)
4. Indication of attachment and bonding issues impacting on the parent-infant relationship and infants emotional wellbeing
5. Insufficient previous attempts to address parent - infant relational needs
6. A viewpoint of involved professionals that change would be possible within the infants' timeframe
7. A willingness to engage on the part of the caregiver with a recognition of their relational needs

The exclusion criteria for referrals were as follows:

1. Severe and acute symptoms of mental health difficulties
2. The family were undergoing a serious case review
3. There was a current major complaint against the Local Authority

The sampling method was opportunistic and determined by referral to the service and consent to engage in the service. Upon referral and meeting inclusion criteria for acceptance into the PIMHS, parents provided informed consent to engage with the service. The consent form devised by PIMHS (Appendix C) included consent for the data from routinely collected outcome measures to be used for the purposes of research to support service improvement and professional practice of those involved with the service. This additionally included consent for the thoughts and reflections of clinicians involved in their care to be used for these same purposes. The sample size was six parent – infant dyads deemed high risk pertaining to the issues indicated above regarding the targeted groups for referral. Their relevant, non-identifying demographic and referral information is presented in the following chapter.

The inclusion criteria listed above determined that all the dyads shared some characteristics of presentation in common, and that attachment and bonding issues would be indicated in the parent-infant relationship which would be the main target for intervention. However, the targeted high-risk groups are diverse such that the prevailing needs and circumstances of the dyads could be widely variable. Similarly, the inclusion criteria that the caregiver be willing to engage has implications for the sample representativeness, as the dyads engaged may reflect a discreet group open to therapeutic intervention. Although these are sources of sample selection bias, the intention of the PIMHS was not to target dyads, or more specifically parents, with discreet and easily classifiable presentations. Furthermore, the heterogeneity of the targeted groups, all be they circumscribed as high risk, could be considered a strength in reflecting the nature and 'bias' of real world clinical practice (Deeks et al, 2003).

## 2.5 PIMHS interventions

Assessment and intervention were bespoke and individually tailored to the presenting issues of each dyad. That said, all therapeutic interventions were intended to be relational in nature, focusing on the establishment of a good therapeutic relationship, broadening parental understanding of infant attachment needs and increasing parental reflective functioning capacity. The frequency of input varied both between and within the dyads such that this could be increased or decreased depending on the needs of the parents and infants over time. The stance taken by the PIMHS was therefore in keeping with the perspective that attachment and RF can usefully enrich the formulation and processes of therapeutic services in the context of which other, demarcated evidence-based approaches can be used (Slade, 2008) and practice recommendations that intervention packages are individually tailored according to women's needs and context (NICE, cg110, 2010). The assessments and interventions provided for each case are described in the following chapter.

### 2.5.1 Assessments.

Depending on parental consent, assessment encompassed completion of routinely used outcome measures, described below. In addition to these, risk assessments and care plans were completed for all dyads. If indicated in the particular case, mental state assessment, crisis plans and psychiatric assessment for diagnoses and medication were completed.

### 2.5.2. Therapeutic interventions with parents.

Interventions for the parents included: Cognitive Analytic Therapy (CAT); psychodynamic psychotherapy; attachment based psychotherapy; psychodynamically-informed couple therapy; emotion regulation focused therapy; anti-natal trauma focused work; and home visits and input from a specialist midwife, community mental health nurse and health visitors.

### 2.5.3 Therapeutic interventions with the parents and infants.

Interventions directed towards the parent-infant relationship included: parent-infant psychotherapy; Video Interaction Guidance (VIG); infant massage; and home visits from family support practitioners to provide guidance and support.

## 2.6 Measures and materials

This section outlines the materials used for qualitative and quantitative data collection. The measures are the routinely collected outcome measures used and conducted by the PIMHS, depending on parental consent for completion. The secondary data they provide comprised the basis for the quantitative component of this research.

### 2.6.1 Interview schedule.

Literature suggests that parental capacity to contemplate the infants mind is influenced by the clinician's capacity to contemplate the parents mind (Broughton, 2005; Slade, 2007) and that this is fundamental to the mechanism of change (Cologon, 2013). As such, and in the context of a service comprised on the theoretical foundations of attachment and RF, the researcher developed the interview schedule (Appendix D) on the basis of the PDI. Questions were adapted and re-framed to ask clinicians to reflect upon their experiences with the parents and infants in a manner mirroring PDI prompts for parents regarding their children. The rationale was to stimulate clinicians' reflective capacity to contemplate their relationship with the parents and infants supported by the PIMHS using the well-founded framework of the PDI. In keeping with the critical realist stance, the interview additionally sought descriptions of how different layers of the clinicians' social reality interact (Byng, 2002) by exploring how their thoughts and actions, relationships, team culture and inter-agency context may have impacted on the parent and child relationships.

To build rapport, interviews began with an introduction (Nestor & Schutt, 2012), highlighting the aim of hearing clinicians' views, emphasizing there were no right or wrong answers. The first question explored clinicians' views and descriptions of their working context including the PIMHS, themselves as clinicians and the parents and infants. This first question was intended to encourage the clinicians to bring the working context to mind but be open enough to allow new aspects to emerge and be introduced by the interviewee (Flick, 1997). The second question encompassed the clinician's views of their relationship with the parents and infants and included PDI sub-questions that prompt for episodic as well as semantic information regarding the clinicians' relational experiences with the dyads. The third question considered clinicians' affective experiences of the work, again with sub-questions prompting first for semantic and general experiences followed by episodic information regarding specific instances of particular affective experiences of the work. The fourth question explored clinicians' professional histories moving from the first time they recalled considering parent-infant work through their professional journey in order to promote a developmental context for the interview mirroring the PDI and developmental focus of the work for the parents and infants. The fifth question concerned team working and professional relationships to consider experiences of de/synchronicity among the team and experiences of support. This question also served to allow issues of the operationalization of the PIMHS to be raised, as recommended for real world project research (Bamberger et al, 2010). The sixth question covered experiences of separation or loss in the work, again mirroring the PDI. The seventh question concerned perspectives and experiences of change or no change with the parents and infants. This did not follow the PDI framework and was included to specifically promote reflections on possible mechanisms and contributors of change. The final and eighth question concerned reflections about what the clinicians would and wouldn't change of their times with the parents and infants. It served as an opportunity to integrate the preceding aspects of the interview. Within this final main question, interviewees were also given opportunity to add any further comments, allowing interviewees to raise issues they feel may be pertinent that lay outside of the interview schedule (Flick, 1997). Across the questions, clinicians were prompted to consider the impact of the topic areas covered on their relationships with the parents and infants in order that relational experiences and opinions on what may enable or preclude change were embedded throughout. The schedule was used flexibly to respond to participants' comments and clarify details (Britten, 1995).

The interviews were retrospective, asking clinicians to think back across their time with the parents and infants. It is acknowledged therefore that the clinicians' memories may have been remodeled over time (Flick, 1997; Byng, 2002). A related issue is that clinicians were asked broadly to consider the parents and infants, rather than prompted for information about each specific dyad in turn. This was rationalized as to cover each dyad in a level of depth would have taken considerable time. Furthermore, the retrospective nature of the interviews has implications for the extent that it would have been possible for the clinicians to demarcate and talk specifically about each dyad. It is acknowledged therefore that the experiences recounted may have held particular salience to the clinicians to be chosen to be recalled (May, 1991) and may not be representative of clinicians' relational experiences across the dyads. The complementary nature of the quantitative component of the research may go some way in providing a different perspective and story of change for each of the dyads individually.

### 2.6.2 The Clinical Outcomes in Routine Evaluation - Outcome Measure (CORE-OM, Barkham et al, 1998).

The CORE-OM (Appendix E) is a 34-item self-report measure covering domains relating to subjective wellbeing, symptoms (anxiety, depression, physical problems, trauma), functioning (general, close relationships, social relationships) and risk (risk to self, and others). Half of the items concern low intensity problems (such as "I have been irritable when with other people") and half consider high intensity problems (such as "I have hurt myself physically or taken dangerous risks with my health") in order to increase sensitivity to change (Evans et al, 2002). Eight items are positively framed and reverse scored (for example "I have felt warmth or affection for someone"). Respondents' rate items according to how they have been over the last week. Items are scored on a five-point scale from zero ("not at all") to four ("all the time") with higher scores indicating more problems. Mean scores are calculated by dividing total scores by the number of completed items.

All domains have shown good internal reliability and convergent validation against existing measures and clinician ratings of risk. Test-retest stability on all domains bar risk is high, although this may be expected given the situational and reactive nature of the risk items (Evans et al, 2002). The measure has shown excellent discriminate validity in clinical versus non-clinical populations with small confidence intervals indicating precise estimates. It is grounded within the paradigm of practice-based evidence (Barkham, Mellor-Clark, Connell & Cahill, 2006) and wide investigations of its use have provided cut-off scores and referential data to establish the reliability and clinical significance of changes in scores based on the Jacobsen-Truax procedures. It has been used with samples of women in the perinatal period (for example Brugha, Morrell, Slade & Walters, 2011; Morrell et al, 2009).

### 2.6.3 The Mother Object Relationship Scale - Short Form (MORS-SF, Oates & Gervai 2003).

The MORS-SF (Appendix F) is a 14-item screening tool assessing difficulty in early mother-infant relationships. The measure is assumed to tap the mother's internal working model of attachment with regards to her infant through items asking about her perception of the infant's behaviour towards her as warm or invasive. There are two resulting subscales, "warmth" and "invasion". The former includes items such as "my baby likes doing things with me" and the latter includes items such as "my baby annoys me". Descriptors were developed based on research of mother's narrative accounts of their infant's thoughts, feelings and behaviours (Oates, 1998). The items are measured on six-point scale from zero ("never") to five ("always") with a maximum score of 35 per subscale. Higher scores indicate higher maternal perceived levels of warmth and invasiveness. The items focus on infant behaviour, which is assumed to minimize social desirability response bias (Davies, Slade, Wright & Stewart, 2008). However, in two separate studies (Simkiss et al, 2013; Davies et al, 2008), negative and positive skew has been noted regarding responses on the warmth and invasion scales, respectively. Thus the measure may not be robust to social desirability bias. Internal consistency, test-retest reliability, and concurrent and discriminant validity have been demonstrated to be adequate (Davies et al, 2008; Oates, Gervai, Danis, Lakatosb & Davies, submitted).

### 2.6.4 The Parent Development Interview (PDI, Aber, Slade, Berger, Bresgi & Kaplan, 1985).

The PDI is a semi-structured interview consisting of 45 items, taking approximately 90 minutes to administer. The PDI is designed to assess parental representations of their infant, themselves as parents and their relationship with their infant, such that it is based on a current and ongoing relationship with a specific child (Slade, Grienenberger, Bernback, Levy & Locker 2005). Scoring is typically carried out using the RF scale, as outlined in the previous chapter. Verbatim transcripts of audio recordings of the PDI are coded and inter-rater reliability checks should be conducted for both individual passage scores and overall interview scores (Slade, Grienenberger, et al, 2005). Raters must be trained to reliability to use the RF scale to score the PDI. The RF scale applied to the PDI has been used in a study by Sadler et al (2013) evaluating the interdisciplinary, mentalization-based intervention, “Minding The Baby”, for young families identified as high-risk. In Sadler et al’s (2013) conclusions they expressed concern that the lower end of the RF scale may not discriminate adequately between levels of prementalizing such that initial changes in RF may be not observable through the unitary RF scores produced by the scale.

### 2.6.5 The Meaning of the Child Interview (MotC, Grey, 2014).

The MotC was developed by Grey, Kesteven and colleagues within the Family Assessment Partnership in collaboration with the University of Roehampton. It is an assessment tool designed to assess the nature of the parent and child relationship and identify levels of risk and resilience within it. It is a method of understanding the way in which parents think about their relationship with their child by applying a classification system to interviews such as the PDI. It examines and codes parent’s talk about their children, their relationship, and themselves as parents, and classifies the parent child relationship according to a dominant pattern and a level of risk. The coding system combines the method of discourse analysis used to classify the AAI according to the DMM, with the constructs used to describe patterns of parent-infant interaction in the care index (Grey & Farnfield, 2016). Thus the patterns are: sensitive (characterized by discourse indicating a mutually pleasurable experience of the relationship and supportive development of the child); unresponsive (whereby psychological distance from the child is indicated leading to neglect in extreme cases); controlling (involving indications of psychological intrusiveness towards the child and hostile and/or enmeshed relationships in extreme cases); and unresponsive/controlling (in which alternating intrusion and distance occur and the parent’s needs dominate). Level of risk is indicated through the accumulation of high-risk discourse markers and/or a thematic and pervasive failure to take the child's perspective and connect throughout the interview. Risk is classified as high, intervention, adequate or sensitive.

Validity of the MotC has been demonstrated through correlations with care-index patterns and parental RF as measured using the RF-scale (Grey, 2014). The PIMHS outsourced completed PDIs to be classified by trained MotC coders, rather than using the RF-scale, with the justification that the MotC system provided a richer description of parent child relationships that has greater clinical applicability.  The PDI protocol adapted for the MotC and the MotC coding sheet are displayed in Appendix G.

### 2.6.6 Contextual outcomes.

In addition to the measures above, contextual outcomes were collated for the dyads regarding their status within children's services and the PIMHS before and after intervention. Information was collected regarding: whether infants remained with their birth parents; the status of the care orders for the individual parent-infant dyads; and whether the parent-infant dyads continued to be supported by specialist services or had been discharged to universal services. These together with information on the parents' psychosocial wellbeing and functioning as provided by the CORE-OM, may allow a broader, more tangible description of the impact of the PIMHS on the lives of the dyads, which has been lacking from outcome research concerning attachment-informed interventions predominantly focused on changes in attachment patterns/representations (Wright et al, 2015).

## 2.7 Research procedure & data collection

### 2.7.1 Qualitative data collection.

Semi-structured interviews were scheduled in accordance with the participating clinicians' preferences, between November and December 2015. The interviews took place across two children's centers in the PIMHS locality and a university campus, according to clinicians' availability and preference. The interview process took approximately 1 hour and 30 minutes in total comprising consent procedures (clinician participant consent form, Appendix H), completing a basic demographic questionnaire (Appendix I), the interview, field notes and de-briefing. Interviews lasted between 55 minutes and 1 hour 13 minutes and were audio taped and transcribed by the researcher.

Following the interviews, participants and the researcher completed field notes, which were considered an important aspect of the procedure for several reasons. Critical realism recognizes that intended social constructions such as interviews vary in their completeness and success (Sayer, 2004) and considers science a social practice (Easton, 2010). Such recognition requires processes for reflexivity to gain information on the co-construction of the interview experience, which reduces a researcher-focused 'top-down' approach (Bell, 2011). Field notes provided an opportunity for participants to express issues without the presence of an audio recorder in awareness that during interviews people can feel pressured to say 'the right thing' (McEvoy & Richards, 2006). They acted as a method for capturing details from the researcher and participant perspectives that may not have been evident through the recordings (Patton, 1990).

### 2.7.2 Quantitative data collection.

Pre-intervention time 1 measures and post-intervention time 2 measures were conducted and collated by the PIMHS team. They were conducted during the beginning assessment and closing intervention phases of the work with the dyads according to their individual intervention trajectories as opposed to uniformly across the group at discreet time points. The researcher collected the secondary data comprised of the completed outcome measures at time points across summer 2015 through to June 2016.

## 2.8 Analysis

### 2.8.1 Thematic analysis.

Thematic analysis was selected as an appropriate method by which to identify, analyse and report patterns within the textual data obtained through semi-structured interviews (Braun & Clarke, 2006). It has been regarded as a systematic and transparent form of qualitative analysis that taps both manifest and latent content in discourse (Joffe, 2012).

This has particular relevance to mental health practice, and is in line with a critical realist stance, whereby research participants may not necessarily be aware of the mechanisms or conditions informing their overt behaviours and experiences (Willig, 2012). Furthermore, this accords with attachment and RF theory, which emphasizes latent psychological drivers manifesting through overt behaviours and discourse. The process of analyses was thereby both deductive (drawing on the theoretical lenses of RF and attachment theory) and inductive (drawing on the naturalistically occurring themes derived directly from the raw data). This aim of attending to both the implicit and explicit meaning making processes is in line with a contextualist method of thematic analysis (Braun & Clarke, 2006).

Interviews were analysed using the six phases of thematic analysis defined by Braun and Clarke (2006). These progress through familiarization with the data set, generation of initial codes, searching for themes, reviewing themes, defining and naming themes, and producing the report. The process was completed using the software package MaxQDA. In order to maintain methodological quality, attention was paid to deviant cases as well as patterns in order to describe the 'bulk' of the data as recommended by Joffe (2012) and to guard against selective attention (Crinson, 2001). A trail of the processes of analyses documented analysis stages and decision-making processes to aid transparency and verifiability. Stages of the coding framework with extracts illustrating codes, and theme development are displayed in Appendix J. To increase reliability, an independent assessor checked data analyses. Researcher and participant field notes, outlined above, and a reflective log were kept to aid researcher reflexivity regarding interpretations and the co-constructional nature of research processes (Madill, Jordan and Shirley, 2000).

### 2.8.2 Reliable and Clinically Significant and Change (RCSC).

RCSC was calculated using the Jacobson-Truax method (JT; Jacobson & Truax, 1991). The JT method uses two criteria to determine the reliability, using the Reliable Change Index (RCI), and the clinical significance of changes in scores on measures. Using this method, RCSC was calculated for the six parent-infant dyads pre and post intervention data on the CORE-OM and the MORS-SF.

### *2.8.2.1 Reliable Change Index (RCI).*

Reliable change concerns the extent to which an individual's change in scores exceeds the range that could be attributed to the variability of the measure itself. Change refers to either improvement or deterioration. The measurement variability is the RCI (Evans, Margison & Barkham, 1998). It is assessed using the standard error of the difference ($SE_{diff}$) given by:

$$SE_{diff} = SD_1 \sqrt{2}\sqrt{1-r}$$

Where $SD_1$ = the standard deviation of baseline observations of a population; and $r$ = the reliability of the measure.

Cronbach's alpha (α) can be used as an estimate of the internal reliability, and referential data from research studies or services using the same measure are needed to calculate the standard deviation of baseline observations. A change score (the difference between pre and post intervention scores on a measure) exceeding 1.96 times the $SE_{diff}$ is statistically unlikely to occur more than 5% of the time due to measurement error alone.

### *2.8.2.2 Clinically Significant Change (CSC).*

The intention of the JT method of calculating clinical significance was to compare change against socially valid criteria, which Jacobson and Truax (1991) suggested could constitute a score moving from the 'dysfunctional' population range towards the 'functional' population range on a given measure. They suggested three criteria (A, B, & C) to operationalize this process:

> A: A pre to post-intervention change in scores of at least two standard deviations from the 'dysfunctional' population mean in the direction of functionality. This criterion does not compare the end score to a reference 'functional' population (Evans et al, 1998).

> B: The change in pre-post interventions scores brings the client to within two standard deviations of the ‘functional’ normative sample mean. This criterion does not capture the extent to which the client has moved away from the ‘dysfunctional’ sample (Evans et al, 1998).
>
> C: The post-intervention score places the client closer to the mean of the ‘functional’ population than it does to the mean of the ‘dysfunctional’ population. This criterion is the least arbitrary and is based on the relative likelihood of a score ending up in functional versus dysfunctional population distributions (Jacobson & Truax, 1991). Criterion C requires a cut-off point where the likelihood of coming from each of the distributions is equal.

When distributions between functional and dysfunctional populations overlap criterion C is best. In this instance criterion A may seem stringent and criterion B too lenient, such that a client’s score needs to move considerably to meet the criterion A threshold for clinical significance versus moving a little to meet the criterion B threshold. In non-overlapping distributions B is most credible (Evans et al, 1998). In addition to this consideration, distributions with different patterns of skew will affect interpretations of the extent to which a score change should be considered clinically significant. Similarly, although simplicity of the method provides a clinically accessible tool for practice-based evidence, the comparison of two distributions has been criticized for being simplistic and assuming a bimodal distribution (Wampold & Jenson, 1986). The JT method has been criticized for being too conservative with respect to clinical significance whereby a mildly symptomatic client whose pre-intervention score is below the cut-off between functional and dysfunctional populations cannot make clinically significant change. Similarly, a severely symptomatic client may experience a large reduction in symptoms captured by the RCI as reliable, but if the change does not fall within the range of ‘normality’ it will not be considered clinically significant (Lunnen & Ogles, 1998). A converse but related consideration is that changes in scores provided by severely symptomatic clients have greater scope to represent regression to the mean (Speer & Greenbaum, 1995). As a norm-referenced method it is therefore influenced by changes in the choices of reference parameters (Margison et al, 2000). The choices of CSC criteria, and reference parameters for the measures used in the current study will be outlined and justified, along with implications of the criticisms of the JT method, in the results and discussion chapters.

Using RCI and CSC analyses, each parent-infant dyad was assigned a categorical outcome depending on their change in scores on the CORE-OM and MORS-SF as follows:

> Recovered: an individual improves to a statistically significant degree by passing the RCI and meets criteria for clinical significance.
>
> Improved: an individual passes the RCI but not the clinical significance cut-off thereby making reliable but not clinically significant change.
>
> Unchanged: an individual does not pass the RCI or clinical significance cut-off points.
>
> Deteriorated: an individual passes the RCI but in the direction of deterioration.

RCI and CSC calculations were established using a freely available excel programme designed by Agostinis, Morley and Dowzer (2008) which produces graphs to identify whether clients have met RCSC criteria.

### 2.8.3 Descriptive changes.

The MotC method of coding applied to the PDI is a relatively recent system. There is currently insufficient data, particularly from normative samples (B. Grey, personal communication, April 11, 2016) to formally assess the reliability of the system and it's stability over time (Grey, 2014). It is therefore not amenable to RCSC calculations. In the cases of the MotC classifications pre and post-intervention, and the contextual outcomes, descriptions of changes will be provided.

## 2.9 Ethical considerations

### 2.9.1 Service setting.

The research was conducted within the PIMHS and it was necessary to address issues of coercion and confidentiality by explicitly stating that participation on the part of clinicians, and provision of consent by parents for data to be incorporated into the research, was entirely voluntary, retractable and independent of additional contact and work within the service.

### 2.9.2 Clinician participants.

Concerns may have been raised in the clinicians in relation to the potentially exposing nature of being interviewed regarding their experiences of their work with the parents and infants. In line with recommendations for qualitative research, consent was upheld as on-going process throughout the research (Richards & Schwartz, 2002). The use of verbatim quotes in presentation of the data from thematic analyses was highlighted to ensure participants were informed of how the data they provided may be displayed. Clinician participants were given opportunities before, during and after the interview process to withdrawn consent and have aspects of their recordings deleted from the data set. The researcher's contact details were provided to all participants to facilitate on-going communication of any concerns related to the above should participants desire. A list of support services was offered to participants to permit access to support independent of the service, which none took up.

### 2.9.3 Parents and infants.

The secondary data that was provided by the parents and infants was part of the routine clinical activity of the PIMHS. No assessments, measures or interventions were undertaken with the parents and infants outside of those conducted as part of their routine contact with the PIMHS. It is a limitation that the research lacked the opportunity to benefit from the perspectives of the parents. However, this was felt to be appropriate and respectful of the time and contribution they had already given through completion of the routine outcome measures, within the context of on-going care proceedings.

The intention to interview clinicians regarding their relational experience of working with the parent-infant dyads was made explicit to parents upon initial consent to engage with PIMHS to safeguard the process of informed consent. This component may have raised worries in the parents. However, it was hoped that through information provided on the purposes and value of the research, as well as ensuring anonymity in the collection, analysis, presentation and dissemination of results, these were lessened.

The parents and infants were deemed high risk and all were initially involved in care proceedings. Awareness that the data they provided through engagement with the service would be incorporated into the research upon their consent had potential to cause distress supplementary to that which may have arisen through the process of assessment and treatment. However, a team of experienced mental health professionals supported the parents and infants throughout and as stated above the right to withdraw consent and/or not consent to the routine assessments was explicit throughout the procedures. Furthermore, in the context of the long-term intervention and commitment this required of the parents and infants, exploration of the processes of the work and change was considered to have an ethical purpose.

### 2.9.4 Research procedures.

Consent forms and data were stored separately and securely on a password-protected computer and locked filing cabinet. One password-protected document, kept by the researcher, linked clinician identifying details with their assigned participant numbers. Bar consent forms all study documentation used only participant’s assigned numbers. Consent forms and information sheets were sent by email to the clinician participants at least 24 hours ahead of the scheduled time for semi-structured interviews to allow participants time to familiarize with and consider the research purposes and procedures. The process of research dissemination within the service and related contexts was outlined. During the interview process, clinicians were given time and opportunity to re-read the information sheet and ask questions before being asked to sign the consent form.

As is necessary in maintaining rigour in research, but perhaps particularly so where asking others to reflect on their relational experiences, self-reflexivity and examination of the researcher's own position and experience of participating in the research was important in safeguarding a high standard of research and thereby participants' contributions. Field notes, thesis supervision, and a reflective log were methods employed by the researcher to aid this process.

### 2.9.5 Ethics committee approval.

Ethical approval to conduct the current research was granted by the research and development manager of the PIMHS host Trust and the University of Essex ethics committee (Appendix K).

# 3. Results

This chapter begins by presenting the results of the thematic analysis, followed by the analyses of outcomes for the parents engaged with the PIMHS. It ends by considering how the outcome analyses contextualise the qualitative inquiry.

## 3.1 Thematic Analysis (TA)

Ten participants, two men and eight women, were interviewed. Their ages ranged between 29 and 71, with a median of 44.5 years. Their professional roles encompassed: nurse therapist, community mental health nurse, family support practitioner, social worker, child psychiatrist, clinical psychologist, occupational therapist/mental health practitioner, and psychoanalytic psychotherapist. Five held bachelor's degrees, three master's degrees, and two had doctoral training.

TA was performed to address the primary research aim of exploring the PIMHS clinicians' relational experiences with the mothers and infants they work with, and their reflections on therapeutic change. TA produced five main themes each with corresponding sub-themes (Table 3.1). Four themes were conceptualized as relating to different levels of relational context, with the fifth organized as a connecting theme with relevance to the other four. This conceptualization is illustrated graphically in Figure 3.1.

When discussing themes, quantifying language pertaining to the number of participants referring to a theme is used as an indication of the consistency of themes and sub-themes. In data illustration using quote extracts […] is used to indicate text removal, *italics* are used to indicate participant word emphasis and ('profession'/'parent'/'families') is used to clarify to whom reference is made. Quotes are attributed to participants via participant numbers (P1 – P10).

Table 3.1

*Summary of themes*

| **Themes** | **Sub-themes** |
|---|---|
| 1. The overbearing wider context | 1.1 Oppressing |
| | 1.2 Resisting |
| 2. Professional Positioning | 2.1 Risk |
| | 2.2 Othering and splitting |
| | 2.3 Therapy in a legal context |
| 3. Dyadic/Triadic relating | 3.1 Being with |
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| | 3.4 Parental ownership and recognition |
| 4. The self in the work | 4.1 Identification and passion |
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| | 4.3 Stance |
| 5. Connecting and Expanding Understanding | 5.1 Having a space |
| | 5.2 Research, literature, and training |
| | 5.3 Symbolizing |

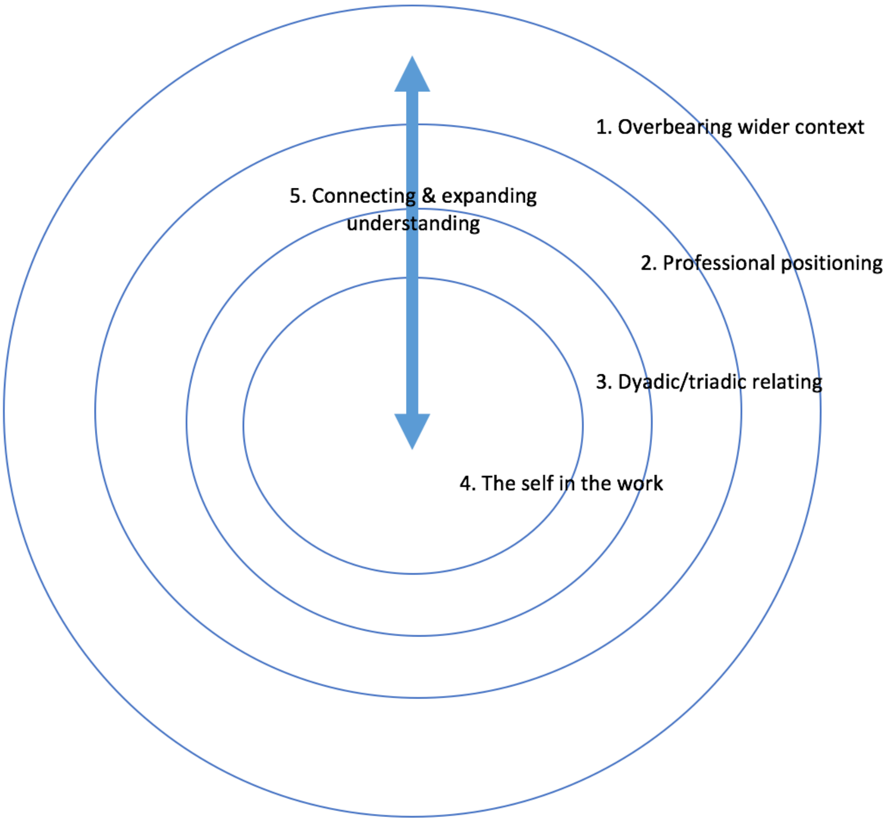

*Figure 3.1*: Thematic model

### 3.1.1 Theme 1. The overbearing wider context.

The overbearing wider context captures institutional and social factors discussed by participants as a permeating backdrop to their work. The oppressive nature of these processes had direct implications for practical and relational aspects of the work, but could be resisted against.

#### ***3.1.1.1 Sub-theme 1.1 Oppressing.***

All participants discussed the current context of health and social care services as restricting and threatening the integrity of the work, splitting families and potentially the service. Lack of financial resources was prevalent in the talk, with the instability this created straining professional relationships, “there was very little certainty with respect to whether the project was going to continue […] we were in doldrums and relationships became a bit strained" (P10). Another participant commented "it's a political debate because of finances and staff time […] but we're supporting permanence of families we need to support permanence within the team and bureaucratical restriction will pull it apart" (P6). A burden of being resource-less seemed to be carried by the clinicians having come from above, for example:

> We might all sit at pimhs and say the baby should be in a mother *and baby* placement but the reality is we have no placement […] we'll do what we can in terms of supporting contact but actually we don't have the power to do anything. P9

One participant described how in a resource-less context, the lack of practical options threatened to harm and even replicate previous abuses experienced by one mother, indicating direct relational and psychological consequences of practical restraints:

> Where are we gonna do this, we're not confident doing it in the community, we don't have alternative resources and that responsibility on us to develop a care plan that's gonna work but knowing that's going to result in her (parent) going to specialist parent infant mental health hospital and she's experienced a lot of institutional abuse so that setting was never going to be a nurturing environment for her it was gonna create emotional turmoil. P2

Two participants spoke about the unmet needs of families not supported by PIMHS, "I *have* wondered are we putting too many workers in, we only take six (families) but there are another 60 out there and other families aren't getting this […] out of the six cases in pimhs three of them are in our area, we've worked hard to get them there but the other areas uh so we've more" (P8). Underpinning and typified in this comment seemed to be an ethical dilemma driven by a narrative of a stretched wider context in which only some can have. P6 similarly commented "social care are working flat out, overworked, underpaid, very stressed, mental health have massive demands, emotional demands, going through restructures that don't fit their ethics and why this do this work".

All participants discussed a backdrop of inhibiting social and systemic issues for the families, illustrating the complexity of the client group. Clinicians talked with an awareness of families starting the work from a difficult and disadvantaged position related to wider, societal issues:

> They're (parents) so damaged themselves and been mistreated in their own childhood and to me that just seems so profoundly wrong that as a society we haven't figured out a better way of helping these parents. P1

Mirroring the resource pressures surrounding the PIMHS, were financial and housing pressures on families, with P1 commenting "as a family they were really stressed a lot of the time […] there was a big financial pressure upon them" and P5 describing how "they may be ok one week and being evicted the next". This highlights a lack of basic, physical stability for some families upon which they were embarking on therapy with its own psychological demands.

Clinicians identified both the families and PIMHS itself with marginalization. Seven participants discussed the notion of the PIMHS being "overlooked" (P5), and isolated families being written off:

> These are mums that people would have written off *instantly* before even meeting them have said we need to remove that child and that's like hold on a minute let's just take a step back and see. P4

> We lost our midwife and this void that she left and then I don't know services haven't really engaged with us properly since. P3

Accounts of marginalization were often accompanied by anger and frustration which was less present in the themes pertaining to other relational contexts of the work. Regarding prevailing negative opinions about the mothers they work with, two participants discussed difficulty in managing social pressures to de-align with the mothers and their own opinions, "there's always the risk of I give up this isn't working because there can be a lot of pressure to see it *our* (social care) way just see it our way, if you're one of very few people who are seeing it a different way it's difficult" (P7).

Longer-term financial savings associated with early intervention to keep children with their birth families were commonly relayed as a justification for the work. Closely linked with this was talk of needing evidence and proof of change, commonly on behalf of the work itself:

> I see the importance of measurement tools and assessment to prove the worth of the work we do to show movement, progress, because without that we wouldn't be able to prove the effectiveness of what we do and we wouldn't be doing what we're doing now without it. P6

> VIG is recommended by NICE as a very effective intervention to be offering to families we can *see* through the films that there's a noticeable difference. […] sometimes the workers' got *too much* to choose from so you can see a market improvement […] so you've *got* tangible evidence there. P8

These comments are illustrative of the pressures to obtain observable and concrete evidence of therapeutic change held by the clinicians. A language of justification of their practice seemed to be disseminated among the PIMHS and framed with a business and financial rationale before one of care, typified in P2's comment regarding the PIMHS meetings "it gave me language to justify my practice […] to be able to demonstrate in the long term this is more cost effective […] and is absolutely in the best interests of the baby". One participant considered whether supporting less complex families would enable PIMHS "to demonstrate more success, more evidence of overt successful outcomes" (P8) indicating the possibility that the need for evidence could reinforce marginalization of the most complex cases.

Within this context of limited resources, participants discussed demands to get "lots more families seen" (P5) with an awareness that potentially premature endings with families "can be really destructive and then you lose all the financial benefits of having been there in the first place" (P3). Participants spoke with an acute sense of responsibility and concern about ending with families using descriptors like "cut off" (P4), "abandonment" (P8) and "pull out" (P6). Here, there seemed a dilemma and embedded fear that the context would not necessarily allow an ending driven by the interest of families, “I think it could be quite damaging to pull out too quickly but it again comes back to capacity” (P5).

#### ***3.1.1.2 Sub-theme 1.2 Resisting.***

Although the wider context seemed to evoke a sense of powerlessness and restriction in participants’ talk, also present were indications of how participants and the PIMHS resisted and pushed against the wider context. Four participants identified the community setting of the PIMHS as a neutral, less stigmatizing space for families by virtue of which the extent that the families might be ‘othered’ and marginalized could be lessened.

> Within children’s centers the idea is of a seamless transition between universal and targeted services. Whenever you put a specialist service in a children center setting there’s no need to think of that family as permanently disabled. The idea is that they may need more for a while but then they can go back into targeted or universal services so I think there’s less stigma. P1

Participants discussed the community setting as inviting and comfortable, a “ready-made bed […] to nest in” (P8), that seemed to hold the potential of relaxing the vigilance of families “weary of different agencies and so the need to meet with them (families) where they feel most comfortable physically as well as metaphorically in their homes and children’s centers” (P10). Linked to the importance of working in a neutral, comfortable space, six participants identified with a non-medicalized model and approach. Rejecting the medical model seemed to be an act of resistance whereby relating to people, rather than labels, might create a space for optimism and therapeutic change.

> I come out of the mental health thing and *see* them (parents) just as a person which is what they are. Having problems. (P4)

> It isn’t fictitious illness and we were able really to limit the number of times that she (parent) was presenting at hospital […] the fictitious illness *label*

> seemed to disappear I think when we can see the way it functions rather than actually pin a label and try make her fit into the label which we could've done easily. (P3)

> For me it didn't feel like an organic illness but a product of the environment that they (parent) experienced growing up and there's things you can change about environments and relationships. (P2)

Similarly, five participants discussed opposing dominant narratives regarding parenting, which could be undermined in the legal context but unless challenged served a function of repressing parents' feelings and self-belief.

> We (PIMHS) might bring a perspective that emphasizes the damage to a parent or their improvement and if that doesn't fit with a narrative of this is a bad parent whose child is in danger then that can get lost quite quickly within the court process. P1

> I think the desire's always there, the belief they (parents) can do things differently is what's missing, often the idea is I'm a bad person I'm a bad parent and that gets in the way because often they feel quite hopeless. P5

Linked to this, seven participants discussed the importance of advocating and looking for 'good enough' parenting, for example "it's very much about the good enough, it's not about being a perfect parent because they don't exist" (P5). However, the concept of 'good enough' was itself mysterious with one participant raising that without clarity on what this entails parents and professionals alike might remain uncertain if they had reached this:

> We need to be clearer about what good enough looks like, without that it's really hard to know whether you've got there or not […] families they need to know where they're going and what that will look like […] if it's hard for us what must families think like well when are we ever going to be *good* enough. P9

Participants unanimously gave illustrations of successes of the work and parents framed as having proved expectations wrong and overcome expected failure. These instances seemed to be reified as something to oppose marginalization with and to have conviction in the worth of their work:

> He (infant) is the focus of her (parent) life, she'd do anything for him and I just feel so privileged to be able to be a part of that because this is the mum that everyone had written off and I think don't write *don't* don't write her off because *look* at what a great mum she is *look* you know look at what she does. P4

> Here was a family, usual, drug addict, previous children removed, and then suddenly six months in this family's really engaging and it's lovely, they've been deescalated off of the risk and they're down to team around the child. P3

> Just makes it feel *worthwhile* it makes all the *not* so good bits worthwhile it just feels like when that happens there's potential for someone to really move forward and make a difference. P5

### 3.1.2 Theme 2. Professional positioning.

Professional positioning captures extensive references by participants concerning professional dynamics and conflicts particularly around the nature and concept of risk, most frequently discussed as risk of harm towards the child. Participants discussed a polarity regarding the 'know-ability' of risk seeming to organise participants into two groups, from which professional splitting could occur with ramifications for the coherence of the work with parents.

#### *3.1.2.1 Sub-theme 2.1 Risk.*

All participants discussed the presence of competing and conflictual conceptualisations of risk, which eight participants broadly polarized and attributed as belonging to those of mental health versus social care professions. The polarized nature of these conceptualisations centred around differences between those that could distinguish between thoughts to harm versus intentions to harm (mental health professionals), and those that did not (social care professionals).

> Someone with intrusive thoughts around harming their children to us with mental health hats on it’s an intrusive thought, they’re fearful they’re going to act on it so they very rarely would. From other disciplines to hear someone’s having thoughts to harm their children sends alarm bells and makes people fearful. P5

> The difficulty between mental health and social care perspectives is they’ve got very *different* understanding around how we hold and manage risk […] someone who has a stronger understanding around mental health and research base around that whereas social care have an understanding around *physical* and *visible* risk indicators it’s more *difficult* for them to qualify emotional risk, the two don’t blend and there’s been a fracture between the mental health and social care perspective. P6

> There’s a difference between expression of strong feelings or thoughts and intent. A mother might say I feel like killing myself and suffocating my baby whereas that may be taken at face value and a need for drastic action, on the other hand the mental health team may be able to put that in context, tease out whether that’s just an expression of feeling very dysregulated and whether there’s actually intent there, and that’s a tension. P10

The polarized understandings of risk imply that mental health professionals apply a phenomenological approach to risk whereby exploration of mothers’ subjectivity ‘teases out’ a latent understanding of risk as an expression or intention. In contrast, the implication for the social care approach is of an objectivist stance based on surface level, observable signs of risk. Associated with this binary distinction, the social care perspective seemed to be relegated by the mental health perspective. The stance assigned to social care seemed to imply “knee jerk reactions” (P4) and less sophistication and comfort in managing risk.

> Social care felt de-skilled by not knowing as much as mental health professionals and mental health have felt frustrated around the lack of consistency with how social care sit with risk. P6

> Social workers come to pimhs, ask for consultations but then go away again not really understanding it, *still* just not getting it at all. P7

Attributions regarding where these different perspectives stem from clustered around training, the nature of different roles, and different views regarding 'who' professionals' clients were, the parents or children.

> What she (parent) says is disturbing, worrying and risky but because we've got a mental health background we hear these things a lot of the time, the impact on us is very different to a social worker. P4

> When you have very different *focuses* about *who's* your client you see risk really *differently*, from our (social care) point of view our clients are the children and we want to see things from *their* point of view where adult mental health see *mum* as *their* client from their point of view she's doing ok. P9

Five participants alluded to the impact of these different perspectives on risk as a "chaos" (P10) in which an unhelpful relativism was created. Alternative beliefs about the seriousness of parental verbalizations regarding harm could lead to different courses of action and relay a message of no truth to parents in which assessment of risk was too far reduced to opinion.

> It gives them (parents) a message that there is no truth, that truth is relative when it comes to babies and small children and one person's opinion is just as good or as bad as the next and I think that's unhelpful. P1

#### ***3.1.2.2 Sub-theme 2.2 Othering and splitting***.

Closely linked to differences regarding professional understanding of risk was a process of 'othering' in which social workers were depicted as threatening, and "ultimately responsible" (P6) for the removal of a child primarily without recourse to other situational factors that contribute to removal.

> Social work practice in those really tough cases […] they shut themselves off from these parents, their stories and their lives to defend against just how destructive what they often have to do is. P1

> It was absolute fear, I (indicating parent) don't want to allow myself to get attached to this baby cos I already know social care want to remove it and that was a genuine fear grounded in reality. P2

> Someone said you're (social care) just going to take these children *away* and it was like we've *never* said that but they're like but you could do it. Well yeah we could but we would have to have reason to, we're not just gonna do it […] there's still quite a naïve belief that children's services are these horrible people that just swoop in and take people's *children* away. P9

The ultimate responsibility of social workers appeared to be both protested against, and relied upon in shifting responsibility away from mental health staff, and compartmentalising the therapeutic context from the legal one.

> I (mental health) don't present that risk of I'm going to take your children away they (social care) do yet *I'm* the one that can build up a relationship with parents. P4

> We're (mental health) not the ones who take action that's where the interagency working comes into play, children's services take whatever steps they need to take but continuing the therapeutic role alongside that is key. P10

Locating blame and danger within social care could also serve the function of removing these from parents, potentially protecting the therapeutic alliance. As indicated in the illustrations below, the location of blame within social care appeared deeply felt by both mental health and social care participants.

> I (mental health) said it made me feel *fearful,* I feared that you (social care) were going to remove the children, *shock* why would *you* feel that? Well I listen and I was thinking if I was that mother I'd really fear for the safety of my children that you were going to take them away. P3

> She (mental health) should have some faith that we're (social care) not going to be that abusive to her client. It just felt like what do you think we're going to do? P9

The role of the social worker seemed to become conflated with a superordinate power, with "directives coming from above" (P5). The implied objectivist approach to risk taken by social care may act to create a certainty in their decisions within the context of being positioned as ultimately responsible.

Related to professionals positioning regarding risk, references to splitting were made by eight participants. The origin of professional splitting was almost unanimously attributed to the families.

> What we're (PIMHS) playing out are the feelings that the mother has. The mother felt unsupported, fearful, all sorts of feelings that were located in the workers when we fell apart over a case […] there are cases that are very powerful where we're assigned roles by the family and we act them out professionally. P3

> It fractures the service […] it is something that has grown from the family that's a very clever dynamic. P6

Only one participant considered otherwise, "often the splitting is seen as coming from the parent but I think that's an oversimplification, I think parents often pick up on the very real splits that are there among the professional system, it's unfair to say the parent does all of it" (P1). In the context of splitting, and in contrast to participant accounts of aligning with a non-medicalised approach, diagnostic labels were used as descriptors for some parents by eight participants.

> Families where the parents have, dare I say it, where there may be issues around a diagnosis of borderline personality disorder, I think those are the families where we might see this at play. P10

Typified in the quote above, the use of diagnostic, most commonly personality disorder, labels seemed to be somewhat reluctantly drawn upon as an explanation for cases of professional splitting and to illustrate difficulty in the work, as below:

> A lot of them have emotional unstable personality disorder so boundaries and consistency are important […] they feel you're gonna reject them so it's *important* that no matter *what* they do, you *still* keep going back. P4

#### ***3.1.2.3 Sub-theme 2.3 Therapy in a legal context.***

As may be expected, the legal context of the work was present in participants talk. A sense of threat of infants being removed was discussed by six participants, with the ramification of potentially silencing parents engaging in therapy.

> Every parent in this project must be enormously fearful that they will lose their baby so how much they say is very much governed by that. They may say things they think we want to hear rather than what's truthful. P3

> We can support you to be a better parent but if you don't *tell* us, but they're *frightened* to, if I tell you this I've had thoughts to hit my child but it doesn't mean I'm gonna hit them but I've had thoughts and I daren't tell anyone because I think you're gonna remove them. P4

The uncertainty of removal also raised an ethical dilemma for one participant who questioned supporting a bond between a parent and infant which may be broken, "ethically is it right to continue to strengthen this bond between this mother and baby when in the background we know social care are pursuing to remove the child" (P2). Similarly, two participants described the uncertainty of removal from parents' perspectives as limiting the extent to which parents may allow themselves to be parents, "he didn't want to be a father if he was going to lose his children because he didn't want his children to suffer as he did" (P3).

Five participants made references to risk as the bottom line in the work, with risk necessitating a move from a dichotomised therapeutic to legal stance towards the parents.

> We tread between having a therapeutic relationship, having a truly reciprocal dialogue going on and on the other hand having to carry the risk […] to switch mode and understand very quickly, make a decision around risk very quickly and an action plan that means the baby and the mother will be safe. P10

The legal context appeared to permeate the therapeutic relationships, with parents and professionals heavily aware of the threat and uncertainty of removal of the child potentially fostering suspicion and silencing in parents, and conflicting modes of relating in professionals as therapist versus safeguarder. Additionally, one participant raised the issue of compliance, with potential consequences for an authentic, mutual engagement in the therapy:

> I don't think she (parent) felt she could say no because she was involved with child protection, so there was always that you're doing this to comply, you're doing this to *engage* with the services that are being offered. P7

Transparency was a bedrock of the work for five participants, and described as a remedy for navigating therapy in a legal context that might allay issues of confidentiality and protect a collaborative relationship.

> Pure transparency, we have to name everything exactly as it is which isn't typical therapeutic work where that information's more contained within the therapy room. P6

> Explaining to them (parents) ok you may not like this but this is what's gonna happen, let's work together to deal with this rather than try and hide it, it's about being totally transparent. P4

However, one participant described the power of legal and professional language within a therapeutic relationship in which the word 'neglect' was used as a final resort to express the gravity of concerns to a mother. Here the legal connotation of professional language seemed to intrude upon the therapeutic relationship causing rupture:

> Things reached a pitch when in desperation I began to mention the word neglect I said this child is beginning to look like he's neglected and that *word really hurt* them it was very hurtful and that was a rupture, it took a while to recover from that. P10

### 3.1.3 Theme 3. Dyadic/triadic relating.

'Dyadic/triadic relating' captures relational dynamics between the participants, parents and children. Participants discussed connecting and distancing processes in the work, and assumptions regarding what the therapeutic and parent- child relationships could withstand. Indications of change seemed to revolve around participants' sense that parents were gaining a recognition and ownership of their experiences, difficulties, and potential to be a parent.

#### *3.1.3.1 Sub-theme 3.1 Being with.*

The sub-theme 'being with' captures a trajectory of connecting with parents and children, in which nine participants emphasized the interpersonal context of the work and importance of being alongside and with parents and infants.

For six participants there was an awareness of parental ambivalence towards services and the low currency of professional help, setting an initial backdrop to the work.

> It's just another appointment, the currency of people going in to help is low because she's (parent) had so much of it […] anything is like well you can come in but who are you and yeah yeah and it's very much like this line of work whereby they just have so much intervention these parents. P1

Against the backdrop of ambivalence, a “dance of engagement” (P6) would ensue, which seven participants spoke of as an essential aspect of the work, “without it you’ve nothing” (P3). Establishing engagement required a presence and acceptance of the parent in the moment, bracketing professional agendas, and being persistent.

> *Accepting* them (parents) in the moment at the time because you never know what you’re gonna get when you get through that door but it’s about accepting them as they are in that moment and taking a step back and saying ok well what shall we do now. P4
>
> If you can set up something fun and they (families) can *meet* you on that level and if they can’t but you have to adjust to meet them. P6
>
> The persistency, the way the workers keep knocking on doors, keep getting those appointments established in the beginning bears fruit. P8

Connecting with the infant in the presence of the parent could be a way of joining with the family. Here, engaging in play could establish trust and seemed to hold the potential of relaxing vigilance and guardedness of the families.

> With mothers *particularly* under child protection they view mental health as a potential barrier to the parenthood, something that’s being scrutinized […] so having that external little infant that tells no lies helped opened up conversations. P2
>
> She (infant) wasn’t sure about me, she was trying to suss me out […] there was one time we did a jigsaw […] her mum was watching and I enjoyed the fact her mum could see I was attending to her in a playful way cos I thought this is about building trust. P1
>
> It’s the same for the parent as the child, bringing their barriers down, taking down the concerns, taking down the anxieties allowing them to be free and playful. P6

For six participants, being pragmatic and responsive to parents in-the-moment-needs, conveyed a message of really caring, again highlighting a bracketing of professional agendas to centre the parent and relate person-to-person.

> Just a real act of kindness […] I'm gonna take your children out for a couple of hours I'll be *back on* time, you can have a bath and make yourself feel more comfortable […] this mother just needs some comfort, she just needs a space just to get herself up and dressed and little things that actually make the client feel this person really cares. P3

> Simple things like making someone a cup of tea and saying actually I'm gonna make you a cup of- you know when actually I'm just being a person is really important. P9

Participants used the interpersonal context for acknowledging and witnessing moments of parent-infant connection and parental insights, using their knowledge of the parent across time to share in moments of change and love.

> She enjoyed looking at the positive things that were happening between her and her baby and having someone acknowledge those with her […] so she would say something and I would *say* that's quite insightful and she would always have this huge grin. P7

> When she had her baby I saw her in the hospital, she goes I fell in love instantly and thinking about how ambivalent she was during the pregnancy […] she had never been sure if she'd really experienced love or what it would feel like and if she'd be able to recognize it so when she used that word yeah you had to swallow and breath and talk and explore it. P2

There was a sense these moments were also important for participants to hold onto, linking with the idea of proving expectations wrong and overcoming the child protection context:

> This mum’s always enjoyed me witnessing the lovely moments, there was another beautiful moment they were just totally attuned in their own little world and I took this amazing photograph that captures that and I hold onto that because it was an important moment. P10

From a connected position with parents, noticing moments of fear or misattunement between parents and infants could also be held and shared.

> He’s (infant) seeking her out then there’s this one moment and you have to pause to even notice it but she (parent) just lifts her head away to one side and I felt it was really significant and she said well there’s times I feel like whenever they’re (children) all there and all needing me I just feel like this big black hole opens up inside me and I feel like I’m going to fall in and that was the real centre point, that symbolic statement. P1

For six participants, modelling an openness in communication and keeping consistent boundaries was an important process in the work to foster containment. This was hypothesised to have been missing from the parents own experiences of being parented and formed a basis for a re-working and re-experiencing of relational templates.

> It’s really important to be really honest and not bottle it up because I guess the whole point of successful therapy is being able to model. P5

> It’s that consistency, that parenting bit that even if they (parents) behave really badly, they’re really horrible, all the rest of it, we’re still there the next day and we’re still there the day after that. P9

> The level of honesty that you can offer them some level of challenge, it’s safe to challenge them and there’s reason behind it, almost working as that internal working model of a parent, it’s safe to be understood […] with children and it’s the same with these parents who also need that too. P6

For three participants, this developmental process between clinician and parent could then parallel an equivalent process between parent and infant.

> Being part of the development of a trusting, reciprocal, containing relationship so that they (parents) in turn can parent their babies. P10

#### ***3.1.3.2 Sub-theme 3.2 Distancing.***

Juxtaposed with ‘being with’, participants discussed distancing processes between themselves and parents. Parental withdrawal was described with a sense of disappointment and rejection, for example as “we *just weren’t* on the same page at all, it felt very difficult” (P10), and “doing her best to push us away” (P7). Parents might physically withdraw and stop attending appointments and/or begin withholding information and withdraw from open communication. Two participants questioned whether withdrawal followed moments of closeness and recognition of a parent’s feelings:

> You would have these moments with this mum whereby you would feel there was a deep connection and then because of her more ambivalent way of being there would be a sort of dismissal. P1

> It’s worrying at the time because you’re like OK is that distance because I’ve hit the nail on the head here. P2

There was a sense that clinicians could be distanced from their professional role through parental withdrawal and pressures from parents to reject, with participants becoming immersed and drawn into enactments:

> She’s enacted a way of being rejected from someone who’s working hard to be consistent so it’s challenging her own attachment style of I *expect* to be rejected I *expect* to be let down I *expect* that you wouldn’t persist to want to see me and it’s like she’s trying fracture that. P6

> I probably colluded with mum in her ambivalence at times […] probably I was sort of acting out something of my own frustration at the inconsistency of the work really. P1

For three participants, maintaining some distance in the work was important in resisting enactments, empowering parents and minimizing over-reliance on the professional. Here, distance could keep the clinician from becoming rescuing:

> I feel anxious if they're seeing me as rescuing because that dependency doesn't help and means I need to step back. I try and remain aware about the strength in the dynamic of the relationship I have with families because it leaves *them* to be very *vulnerable* if I'm not as available some days […] I try and shift the feeling of power back to the parent to hold it themselves. P6

#### *3.1.3.3 Sub-theme 3.3 When the relationship is not enough.*

Participants described factors that could preclude therapeutic change. Here, the implications appeared to be that the therapeutic and/or parent-infant relationship was unable to withstand outside pressures, with failures of therapeutic change attributed more commonly to systemic pressures on the parent, including distressing life events such as loss, and less commonly to conflicting parent and child timescales for change. Typified in the illustrations below, five participants alluded to a sense that the system around the parent-infant could pull them away from the PIMHS and the potential to change:

> There'd be so much potential if you just had the two of them (parent and infant) as a unit but as soon as you put the wider system around them there's risks to her ability to feel secure and stable […] she'd experienced so much rejection she felt doing rejection was really difficult and she had this sense that they were her peers and if they're the scum and untoward people so am I. P2

> Their (parents) relationship with the baby, sometimes it's just not enough to stop everything else going on, people continue to live in the context of their lives and have those relationships and as much as they want to change, other people around them maybe don't. I think it's asking a massive amount of people to be new parents, to focus on their baby and deal with those external pressures, at times it is just too much for people. P9

Related to this, one participant described a sense that a parent's reflective capacity and resources to cope as articulated in sessions did not extend to outside contexts, "she's able to say the right things but not able to put them in practice, she can appear reflective and communicate what needs to happen but when it comes to it she can't regulate and manage those emotions" (P2). Linking to the depiction of social care as threatening and the marginalization of mothers, three participants considered the incompatibility of parent and child timescales for change as restricting the potential for the work.

> The parent needs longer to resolve entrenched issues, to be freed up enough to meet the children at an appropriate level of care and the *children's* timescales is driven by social care […] the two don't marry. P6

> Children's services have to meet their *deadlines* and *timeframes* so they *give* timelines but they know mum can't meet them expectations because you're not gonna get therapy in eight weeks […] it's almost like not setting them up fail but like it's got to fit in with our schedule and not in with yours. P4

#### ***3.1.3.4 Sub-theme 3.4 Parental ownership and recognition.***

In contrast to systemic factors impinging on the possibility for change, for nine participants a sense of parental ownership and recognition seemed to herald a pivotal point in the work, marking change, insight and parental responsibility. This alluded to an ownership of being a mother, and a recognition of both difficulties and positives in their relationships with their infants and their histories. This process required that clinicians not impose their views in order for parents to have an "emotional connect" (P2) with change:

> Me not imposing that and allowing the time for her to be curious so not just saying well everything's fine, it's richer than that so giving her time to notice the little things that were different and make sense of what that might mean. P1

Parental insights, particularly regarding historical influences in current relationships and ways of being, were discussed with a logic implying self-reflective and psychological shifts initiated change in accordance with literature suggesting the development of self-mentalizing may be an important initial target for change before that of other-mentalizing (Suchman et al, 2010).

> Mother has gained enormous insight and has said I think I'm like my mother and that *insight* for the first *time* that's fantastic she's really shifted this woman and she *knows* she's going to be safe with her child, a real *knowing*. P3

> The mother had a light bulb moment which was pivotal to her making some very significant changes, it was so exciting she had this reflective integrative moment when she saw her mother very differently to the way she had. P10

Implied in the extracts and typified in the following comment, reflective insights and parental ownership pre-empted action and lifestyle changes:

> There was always that dilemma about protecting herself and allowing herself to be that mother so when she started to take ownership of that and become really cued in with the infant and *do things* she would always say she would *never* do such as attend groups and baby massage those were just hugely significant. P2

With a recognition of their own histories and ways of relating, parents might "start beating themselves up a bit less, take a step back and be a bit more compassionate towards themselves" (P5). For three participants, parental ownership and recognition was also striven for in cases of likely child removal with the potential to ameliorate some distress in this context:

> She was given that chance and she was able to put to bed the fact well can I do it or not and she realized *herself* that she couldn't do it, no professional told her, she made that realization herself. P4

In the context of both positive relational change or child removal, parental ownership and recognition seemed to indicate a level of shift from professional to parental responsibility of the situation going forward. The illustrations also imply a shift towards a certainty or knowingness, for example "her to think about what she expected to do, what her role would be in that child's life and for her to able to say it out loud makes it more real, that she could be more sure about it and clarify it for herself too" (P7). This shift towards a certainty stands in contrast to the wider context of uncertainty in the work regarding whether the infant will remain with the birth parent or not, and the unhelpful relativism that could arise from different professional positions about risk. Indeed, this may explain it's apparent centrality in marking change, and representing a point when the need for professional support may lessen.

### 3.1.4 Theme 4. The self in the work.

The self in the work encompasses manifestations of participants' personal selves in the work, primarily spoken about in relation to families rather than other professionals.

#### *3.1.4.1 Sub-theme 4.1 Identification and passion.*

Four participants described a personal identification with the parents, relaying aspects of their own lives and experiences that provided a foundation for empathy and a knowing that could make connecting easier and stimulate a motivation that "we can do more" (P2).

> It *helps* me understand them, I feel like I have a better understanding of these ladies because of my own experience. P4

> I felt like I was quite congruent with what it must be like for her in those moments and I could identify with it [...] I think that makes it so much easier if you can connect with something of the parent's difficulty. P1

Relatedly, four described engaging with the work and context as having the potential to "repair some of my ruptures" (P2). Here, there was an awareness of the personal intertwined with the professional such that professional histories were also "a personal journey of understanding myself better" (P10). Two participants relayed instances whereby personal and professional selves were not necessarily harmonious and could even take different stances towards the parent and context:

> It was really difficult because as a sister I can understand the motivations behind that but as a mother within the social care arena that's not acceptable that's not safeguarding the baby so I at times could completely feel the dilemmas but it didn't counteract the risk. P2

> It doesn't sit comfortably with me but I would say that probably from the families' points of view it's about me being authoritarian, I do have responsibility for making some of those decisions. P9

Here, a personal self appeared to provide understanding and commonality, however, and linking with risk as the bottom line in the work, in these instances the personal self seemed to be relegated by the professional self. From a somewhat more distanced perspective, five participants described their passion for the work, which as illustrated below held a protective function against burn out and group demoralization:

> I feel passionate about giving people every opportunity to do as well as they can […] it makes it more doable because if you haven't got that you burn out much quicker. P5

> The workers' *passion* feels like a *motivating* force for me you know often people can get very *demoralized* and go into a no cycle but the workers have remained in kind of yes cycle about the work undertaken. P8

#### ***3.1.4.2 Sub-theme 4.2 Impact.***

In contrast to the frustrations apparent in participants talk concerning the wider and inter-professional contexts, descriptors of the impact of the work upon the self alluded to states of anxiety experienced by participants. Nine participants relayed instances of being highly aroused with a sense that the work and levels of risk impacted on the physical body:

> I feel completely highly aroused and over stimulated on a Friday afternoon because the work is so emotive […] I don't think it's making me sick but I think it could. P1

> There was a weekend when I actually thought a mother was going to commit suicide and I didn't sleep, I remember feeling highly anxious, it needed a lot of processing really a lot of processing. P3

> There's always a fear of am I gonna think it's ok and it's not, are we gonna make that mistake and somebody gets *hurt* am I gonna miss something, that's always a fear. P7

For two participants, the local historical context in which a mother had committed infanticide and suicide remained a source of anxiety, that "reverberates through" (P9) cases with a similar context and issues, indicating how embedded and felt the work appeared to be for participants, for example giving one participant "goosebumps just talking about it" (P5). Less common but still prevalent, six participants described feeling pain and "immense sadness" (P8) at the removal of infants from their birth parents and at times of parental deterioration. Other instances included the "*really* emotionally draining" (P4) nature of the work, with three participants describing a process of having become less sensitized to the process of removals over time, "I'm not surprised by it anymore I don't have as strong a sense of injustice as maybe I did when I was younger or less experienced" (P1). Although becoming de-sensitized may represent a necessary way of coping and distancing from the emotional context of the work, prevalent in the talk were instances where participants described feelings of inadequacy (seven participants) and a lingering sense of searching for what could have been different (nine participants). These seemed to indicate an on-going processing and impact of the work:

> It was a *very* uncomfortable feeling, looking at *myself* wondering, lots of self-searching wondering how I could have done it differently. P10

> I do wonder she (parent) probably wanted us gone the whole time and so is it just that she's not able to say I'm ok I don't want this anymore but it's easier for her to just not engage. P7

For six participants, having boundaries either could have or did represent a way of bracketing and protecting the personal self in the work. As one participant described it, without boundaries, passion and motivation for the work could cause clinicians to go far beyond their work remit embarking on "a crusade if you're not careful" (P5).

#### ***3.1.4.3 Sub-theme 4.3 Stance.***

This sub-theme captures participants' references to "something very important about what you as a therapist brings into that home with you that needs to be about more than an enactment of a series of techniques" (P1). References to being open (nine participants) seemed more than a professional act, involving using the whole self to receive the parents and infants:

> We have to open ourselves up to those parents to do anything of any use, we have to open ourselves up to their experience and to get in touch with the damage that's been done to them. P1

> The space in my mind to be able to just receive what she's (parent) saying, to be able to receive her without me having to compensate or rescue *myself*. P6

References to openness linked to consistency, with the latter enabling the former, for example, "being able to be consistent with a family makes the relationship easier, to be able to be free with myself in the visit, like open" (P7). As implied in these illustrations openness related to receptiveness and an ability to remain mentally present to the potential pain of families' experiences. From this position, and linking with the importance of witnessing of moments of love and care, openness could also allow unique and bidirectional positive experiences for clinicians and parents:

> Those moments of love between a mother and baby, when you witness it if you're open to it, it's unlike anything else in the world. P1

Nine participants relayed the importance of commitment, again with a sense of this being a personal and imperative stance, as one participant explained, "there's a human element to traumas and sorrows that you can't just ignore and walk away from" (P3).

Commitment and hope were essential in offering parents a perhaps altogether new experience of relating:

> It’s important that no matter what they (parents) do you still keep going back so I’ve always described myself as a drippy tap because I just keep going because that’s how you engage, you don’t give up on them because everybody else in their life has so you have to show them that you’re not gonna give up and that you always hold hope. P4

### 3.1.5 Theme 5. Connecting and expanding understanding.

Connecting and expanding understanding is conceptualised as a theme with applicability to each of the other four themes. For each domain in differing ways, this theme captures the processes by which participants described making sense of and responding to their experiences in the work.

#### *3.1.5.1 Sub-theme 5.1 Having a space.*

At the level of the self in the work, six participants described having a space through supervision and weekly PIMHS group forums for the purposes of digesting the personal impact of the work:

> Me having more space enables them (families) to give more because if I’m not full up, I’m freer to receive what they’re saying, I’ve got more space to be genuine in my curiosity rather than going in with I need to get x, y, and z done today. P6

> Supervision has been really powerful because I know I have a place to go to so that I can be a place for them (families) to go to. P7

Supervision seemed to enable a metaphorical lifting of the weight of “the clinician’s work because some of them carry enormous anxieties and responsibilities” (P3) through which there was room for families to share their distress and have this held by clinicians. Mirroring the necessity of the interpersonal context between clinicians and parents, supervision allowed another to notice potentially unhelpful relational dynamics:

> It needed a certain amount of subtle direction from me to ensure she (mental health worker) wasn't undermining the council's position that the baby needed to be removed, she was very much involved in supporting the mother and the baby so at points couldn't hold the holistic picture. P8

At the level of dyadic and triadic relating, the concept of creating space was drawn upon by seven participants, representing a parallel process of freeing up space for parents to interrupt patterns of relational distress. For two participants, creating space for parents also linked with opposing dominant narratives of parenting whereby a neutral space could allow for subjugated parental feelings.

> Just creating a space for her (parent) to think about it, to kind of step outside the interaction and think about it. P7

> Allowing space to express ambivalence or hatred or jealousy or envy or disgust and some of the more difficult emotions that I think are at the heart of lots of parents' experience. There's a universal component where parents feel quite ambivalent towards their children at times I think, and I hope me taking up a position that allows for that enables them to be open about the slightly darker side of their own parental identity. P1

For seven participants, the group forum was an essential space to address professional issues and dynamics. Here, splitting could be named and differences aired within a "safe arena" (P4). There was a sense that the forum was a defining feature of the PIMHS that formally provided a space for professionals and agencies to come together, "on a regular basis as opposed to just kind of *hoping* that sharing of information happens" (P7). Without this space, differences and splitting threatened to continue and arise in other forums:

> What do you *do* with it? Otherwise you'll implode so you need that forum because you can't suddenly decide well what are my differences today in this

> child protection meeting with the family present […] you can't show parents you're splitting, it's about feeling safe with your professionals that you can say things that are concerning you. P4

In this forum if complementary views could be reached, a "sensitive" (P8) and "tight-knit" (P7) service could be offered to families, perhaps acting as an antidote to the unhelpful relativism created by difference and splitting:

> There might be times when we're *not* all in sync but we are able to have that conversation as a team to get others' perspectives and that can change your viewpoint and why that's grounded in their way of thinking so I think generally we're coming from the same place. P5

> I feel like each member is part of the puzzle and the family's the centerpiece and it's just about working *together* so she feels supported by everybody to try and make this work. P4

Similarly, the forum could foster reciprocal professional respect and trust as a means to counter 'othering'.

> I think an added value of the discussion forums is I've been able to view social care in a different way, to hear their thinking and clinical reasoning whereas in a formal child in need meeting you might not hear their emotional connect to the case. P2

However, creating mutual trust and respect was challenging and tentative in the face of holding responsibility for risk:

> The huge challenge is for social care and mental health to realize that we can *jointly* own the risk if a mother's mentioning suicidal or infanticidal ideas but to persuade each other and trust each other to jointly own that is the challenge. P10

Although the forum was commonly described as helpful, one participant described how this space could be intimidating for social workers, with their limited time to attend meetings negating a shared and equal footing in the space:

> The meetings are really *intimidating* for social workers to come into because it's an *established* group predominantly of *health* people, social workers come in for a bit of the meeting it's almost like they're on the back *foot*. P9

Lastly, the forum was a space in which to share and disseminate knowledge, seeming to serve a function of, and linking with, resisting the overbearing wider context as expanded on below.

#### *3.1.5.2 Sub-theme 5.2 Research, literature, training.*

All participants discussed research, literature and training serving multiple functions again in relation to different contexts of their work. The dissemination of research and understanding appeared to act as a means of resistance to the wider context whereby knowledge provided a powerful justification for the work, particularly in terms of justifying timescales of the work:

> All the research says it's two years, we need to be able to offer support for two years. P3

In the professional sphere research could be disseminated, seemingly with a rallying and grouping function in which the message of the work could unify and inspire passion:

> In that work shop I sat down and it was *life changing, life changing* for me it gave me a *force* really to feel that I needed to discuss it, how we could take this thinking forward […] so we ended up with about eighteen people for a week's training in the middle of august such was the commitment in the team. P8

> I became more and more interested in learning and the more research I read the more interested I became the more interested I became the more passionate I was the more passionate I was the more responsibilities I took on. P6

However, one participant alluded to a hierarchy of professional research bases in which social worker knowledges and methods could be side-lined, indicating a multifaceted experience of social care relegation within different contexts of the work:

> PIMHS is more based on psychological research because perhaps the social workers don't *know* about that they feel like they're not equal […] you have to be quite a strong person as a social worker to *be* clear that actually this is my assessment it is informed by research you know I am an equal. P9

At the level of dyadic/triadic relating, dissemination of research and training could provide a reassurance, expansion of understanding and a "honing" (P4) of skills, allowing development for both those more aligned and familiar by training with parental and infant issues. However, in the case of one social worker, the predominantly attachment-based knowledges shared also created an unease and dilemma regarding their role and positioning as ultimately responsible for the removal of a child:

> In some ways having more knowledge and actually more ability to articulate that makes some of that decision making harder. P9

At the level of the self in the work, research and training seemed to act as a form of professional betterment, reinforcing a concept of research and knowledge as a valuable and powerful for the professional. Here, it could act as a counter to feelings of inadequacy:

> Coming into mental health I felt quite inexperienced so I've always been aware of that deficit and quite motivated to engage in research and think about what we're doing and why we're doing it and skill myself up. P2

### *3.1.5.3 Sub-theme 5.3 Symbolizing.*

Akin to having a space and sharing research, all participants described processes of symbolizing and meaning making as fundamental throughout the different relational spheres of the work. Coming to a shared understanding of parents' situations, in the context of their relational histories was a tenet and central aim of the work which participants sought for:

> Having more understanding of her ways of relating to the children, what that was about and her relationships in general. Once people can start to make sense of things and start beating themselves up a bit less and be more compassionate towards themselves that's about as much as we can hope for. P5

> There was a psychological meaning making going on so I just felt very pleased. P1

> I remember him (parent) saying after he sat on the wall outside just thinking and thinking. You think well *actually* it does have a real impact on people. P3

As illustrated in the above quote, there was a sense that for participants the psychological processing and understanding of parents was an important measure of the impact of the work. As one participant described, symbolizing was perhaps so fundamental as to sound simple:

> It sounds so simple but I think one of the key things is for parents to feel heard and understood, for their experiences to be validated, their feelings to be explored and rationalized with them because once they've processed them they then open up space for new experiences and relationships. P6

Here, symbolizing was associated with creating metaphorical space for parents as a means to new experiences and change.

Likewise, professionals engaged in symbolizing and reflective processes with colleagues in order to process the impact of the work upon themselves, "knowing that

I’ve got that support helps me just take a step back, re-think, re-process my thoughts, be more reflective on my own practice” (P4). Coming to a shared understanding of professional positions and perspectives could also rectify splits:

> We were able to talk about what it means because I think she (colleague) felt like I’m not even sure I’m *seeing* what you’re seeing and explain that to me and she was looking to know more about why I thought the things I thought, it was great we were able to come to a shared understanding. P7

## 3.2 Quantitative outcomes

In this sub-section, analyses addressing the secondary aim to analyze quantitative outcomes for the parents and infants engaged with the PIMHS using pre and post-intervention measures are presented.

### 3.2.1 The parent participants.

Six parents (all mothers) and infants engaged in the PIMHS, and are denoted by participant numbers (M1 – M6). Their basic, non-identifying, and contextual demographics are presented in Table 3.2. Table 3.3 displays the overarching referral context, clinical assessments, and interventions provided by PIMHS.

Table 3.2

*Parent-infant demographics*

| **Participant number** | **Gender of infant** | **Age range** | **Highest level of education** | **Employment status** | **Marital status** |
|---|---|---|---|---|---|
| M1 | Male | 20-29 | GCSE's | Unemployed | Co-habiting |
| M2 | Female | 20-29 | GCSE's | Part-time, unskilled | Single |
| M3 | Male | 30-40 | GCSE's | Unemployed | Co-habiting |
| M4 | Female | 20-29 | GCSE's | Unemployed | Single |
| M5 | Female | 30-40 | Not known | Unemployed | Co-habiting |
| M6 | Male | 30-40 | Not known | Unemployed | Married |

Table 3.3

*Parent-infant referral context and intervention*

| **Participant number** | **Referral context** | **PIMHS assessments** | **PIMHS intervention provision** |
|---|---|---|---|
| M1 | Maternal substance overdose during pregnancy, and worsening mental state including suicidal thoughts. Diagnoses of emotionally unstable personality disorder and depression. | Regular risk assessments; medication reviews | Individual, fortnightly CAT (18 months); weekly parent-infant psychotherapy (18 months); One course of VIG (6 weeks). |

| | | | |
|---|---|---|---|
| M2 | Unresolved trauma impacting on bonding with infant, self-harm, and diagnoses of eating disorder and post-natal depression. | Regular risk assessments; medication reviews | Individual CAT (15 months); regular input from multidisciplinary team (midwife, health visitor, nurse, psychiatrist, and social worker); couple psychotherapy; parent-infant psychotherapy. |
| M3 | Unresolved trauma and concerns regarding emotional neglect of infant | Regular risk assessments | Parent-infant psychotherapy (14 months); two courses of VIG (6 weeks each). |
| M4 | Transgenerational experiences of emotional and sexual abuse with resultant trauma impacting on bonding with infant. Self-harm, previous suicide attempt, and diagnoses of emotionally unstable personality disorder and substance dependency. | Regular risk assessments; medication reviews | Regular input from mental health nurse including individual, emotion regulation work; parent-infant psychotherapy (18 months); one course of VIG (6 weeks). |

| | | | |
|---|---|---|---|
| M5 | Multiple children previously removed into state care due to severe neglect. Substance misuse and previous overdose, self-harm and diagnosis of post-natal depression. | Regular risk assessments; medication reviews | Individual psychodynamic psychotherapy, psychodynamically informed couple therapy; regular home visits from mental health nurse; infant massage (11 months); courses of VIG (7 months). |
| M6 | Unresolved trauma impacting on bonding with infant, severe physical health issues, and diagnosis of post-natal depression. | Regular risk assessments; medication reviews | Anti-natal trauma work (2 sessions); individual CAT (16 sessions); regular, intensive home visits; parent-infant psychotherapy (6 months); one course of VIG (6 weeks); infant massage (6 weeks). |

### 3.2.2 Reliable and Clinically Significant Change (RCSC) calculations.

The two-fold criteria of the Jacobsen-Truax method (JT; Jacobson & Truax, 1991) were applied to determine the reliability, using the Reliable Change Index (RCI), and the clinical significance of changes (CSC) in scores for each participant on the Clinical Outcomes in Routine Evaluation-Outcome Measure (CORE-OM) and the Mother Object Relationship Scale- Short Form (MORS-SF). The processes of these calculations detailed in the method chapter will not be repeated here. Of the three criteria for calculating CSC proposed by JT (1991), criterion C was selected as the most appropriate as referential data representing functional and dysfunctional samples was available through relevant published articles for both the CORE-OM and MORS-SF.

As previously outline, using RCI and CSC analyses, each parent was assigned a categorical outcome depending on the change in scores on the CORE-OM and MORS-SF, as summarized in Table 3.4. RCSC calculations were performed for each participant on both measures using time 1 (pre-intervention) and time 2 (post-intervention) assessment time points. These time points differed for each participant, as detailed below, and were determined and conducted by the PIMHS.

Table 3.4

*RCSC categorical outcomes*

| **Category** | **Representation** |
|---|---|
| Recovered | An individual improves to a statistically significant degree by passing the RCI and meets criteria for clinical significance. |
| Improved | An individual passes the RCI but not the clinical significance cut-off thereby making reliable but not clinically significant change. |
| Unchanged | An individual does not pass the RCI or clinical significance cut-off points. |
| Deteriorated | An individual passes the RCI but in the direction of deterioration. |

The results of the JT analyses are depicted graphically using the excel programme developed by Agostinis et al (2008). As illustrated in Figure 3.2 the x-axis represents participants' time 1 scores and the y-axis participants' time 2 scores. The vertical and horizontal lines represent the CSC cut-off points for the x-axis and y-axis, respectively, dividing the functional from dysfunctional population as determined by criterion C. Individual participants are depicted by different coloured shapes at the point of intersect between their time 1 and time 2 scores. The red circle indicates the mean group score.

For measures where decreases in scores represent improvement (CORE-OM, MORS-SF invasion scale), points to the right of the vertical line indicate time 1 scores falling in the dysfunctional range, with points to the left indicating time 1 scores within the functional range. Points above the horizontal line indicate time 2 scores falling in the dysfunctional range, with points below the line representing time 2 scores in the functional range. The reverse is true for measures where increases in scores represent improvement (MORS-SF warmth scale; Figure 3.3). The black diagonal line represents points of no change, with the red lines either side representing the 95% confidence intervals. Points outside of the red lines thereby represent reliable change scores that are statistically unlikely to occur more than 5% of the time due to measurement error alone. The areas in which the participants' change scores fall thereby correspond to the categorical outcomes defined in Table 3.4.

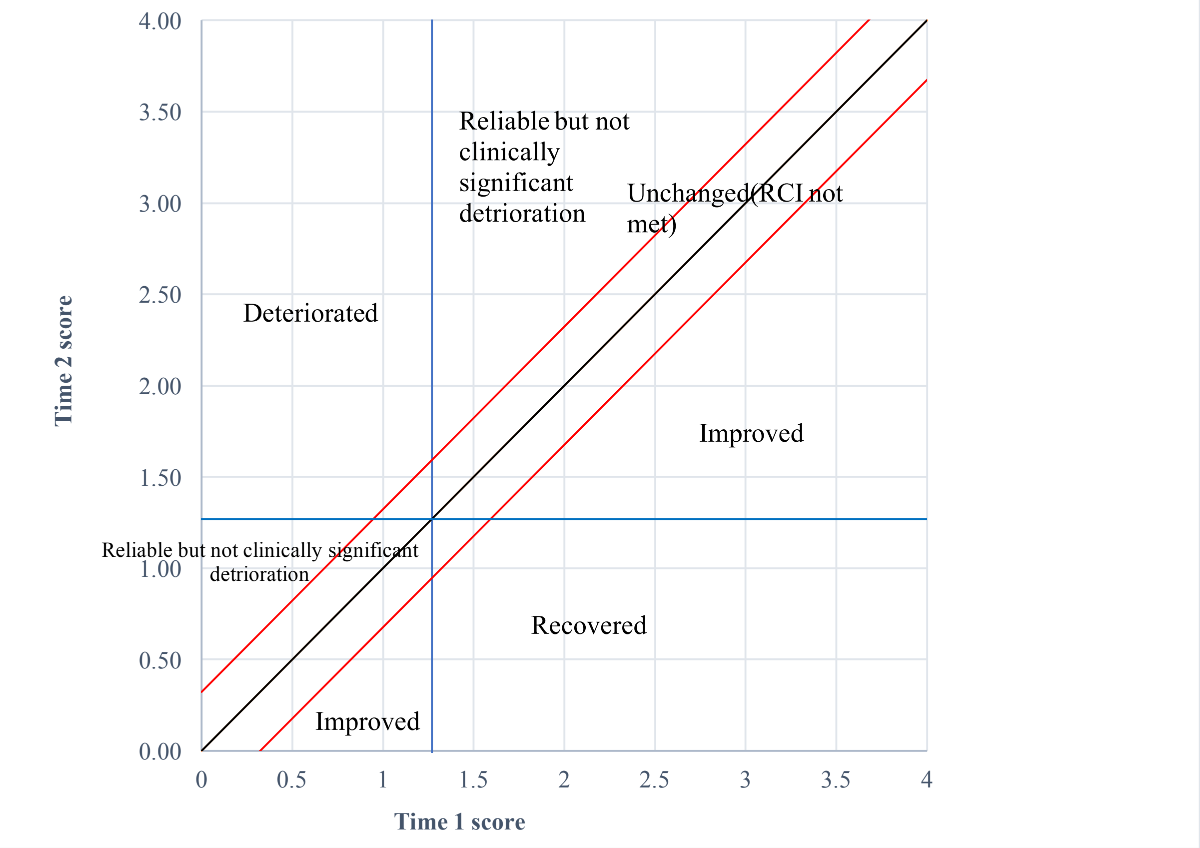

*Figure 3.2*: Graph depicting categorical outcomes using the JT method for measures where score decreases represent improvement

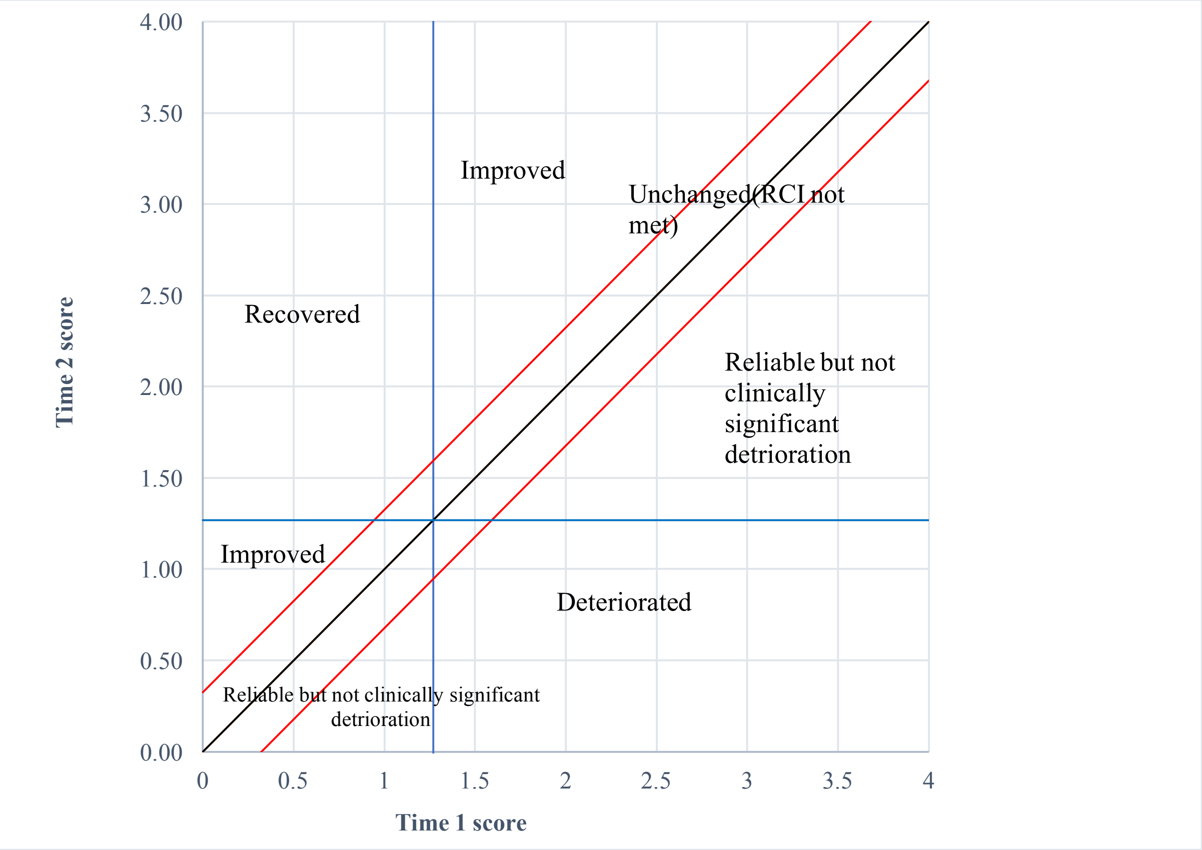

*Figure 3.3*: Graph depicting categorical outcomes using the JT method for measures where score increases represent improvement

### *3.2.2.1 CORE-OM.*

Participants time 1 and time 2 raw scores on the CORE-OM are presented in Table 3.5 and 3.6, respectively. Raw scores are presented for the four domains, total score and mean score (total score divided by number of completed items). The duration between time 1 and 2 CORE-OM assessment for each participant is presented in Table 3.7.

Table 3.5

*Time 1 CORE-OM raw scores*

| **Participant number** | **Wellbeing** | **Problems** | **Functioning** | **Risk** | **Total score** | **Mean score** |
|---|---|---|---|---|---|---|
| M1 | 0 | 20 | 9 | 0 | 29 | 0.85 |
| M2 | 7 | 12 | 15 | 0 | 34 | 1.00 |
| M3 | 6 | 4 | 8 | 0 | 18 | 0.53 |
| M4 | 11 | 24 | 22 | 0 | 57 | 1.68 |
| M5 | 6 | 22 | 15 | 0 | 43 | 1.26 |
| M6 | 10 | 24 | 18 | 0 | 52 | 1.53 |

Table 3.6

*Time 2 CORE-OM raw scores*

| **Participant number** | **Wellbeing** | **Problems** | **Functioning** | **Risk** | **Total score** | **Mean score** |
|---|---|---|---|---|---|---|
| M1 | 9 | 30 | 24 | 2 | 65 | 1.91 |
| M2 | 9 | 24 | 22 | 5 | 60 | 1.76 |
| M3 | 4 | 7 | 11 | 0 | 22 | 0.64 |
| M4 | 1 | 7 | 7 | 0 | 15 | 0.44 |
| M5 | 2 | 6 | 5 | 0 | 13 | 0.38 |
| M6 | 5 | 17 | 10 | 0 | 32 | 0.94 |

Table 3.7

*Duration between time 1 and time 2 CORE-OM assessment*

| **Participant number** | **Duration between time 1 and time 2 assessment** |
|---|---|
| M1 | 1 year 3 months |
| M2 | 1 year |
| M3 | 1 year 3 months |
| M4 | 1 year 3 months |
| M5 | 6 months |
| M6 | 11 months |

As recommended by Evans et al (2002) mean scores were used to calculate RCSC. The female clinical (n = 515) and non-clinical (n = 576) referential norms, and Cronbach's alpha, established by Evan's et al (2002) were used to represent the means and standard deviations of dysfunctional and functional populations, and provide an estimate of internal reliability of the measure (Table 3.8). The female sub-sample data was used as all participants were female and there are moderate and statistically significant gender differences on this measure.

Table 3.8

*Referential data for the CORE-OM (sd = standard deviation)*

| **Source** | **Clinical** | | **Non-clinical** | | **Cronbach's alpha** |
|---|---|---|---|---|---|
| | **Mean** | ***sd*** | **Mean** | ***sd*** | |
| Evans et al (2002) | 1.85 | 0.77 | 0.81 | 0.61 | 0.94 |

To show that the PIMHS interventions had improved parents wellbeing, symptoms, functioning and risk levels, scores on the CORE-OM were required to decrease. Using criterion C, the CSC cut off is 1.27 indicating scores >1.27 lie in the dysfunctional range and scores <1.27 lie in the functional range. Figure 3.4 and Table 3.9 show the results of the RCSC analyses for participants and their categorical outcomes. Three participants (M4, M5, M6) were categorized as recovered. M3 is categorized as unchanged, however their scores fell in the functional range at time 1 and 2. M1 and M2 were categorized as deteriorated.

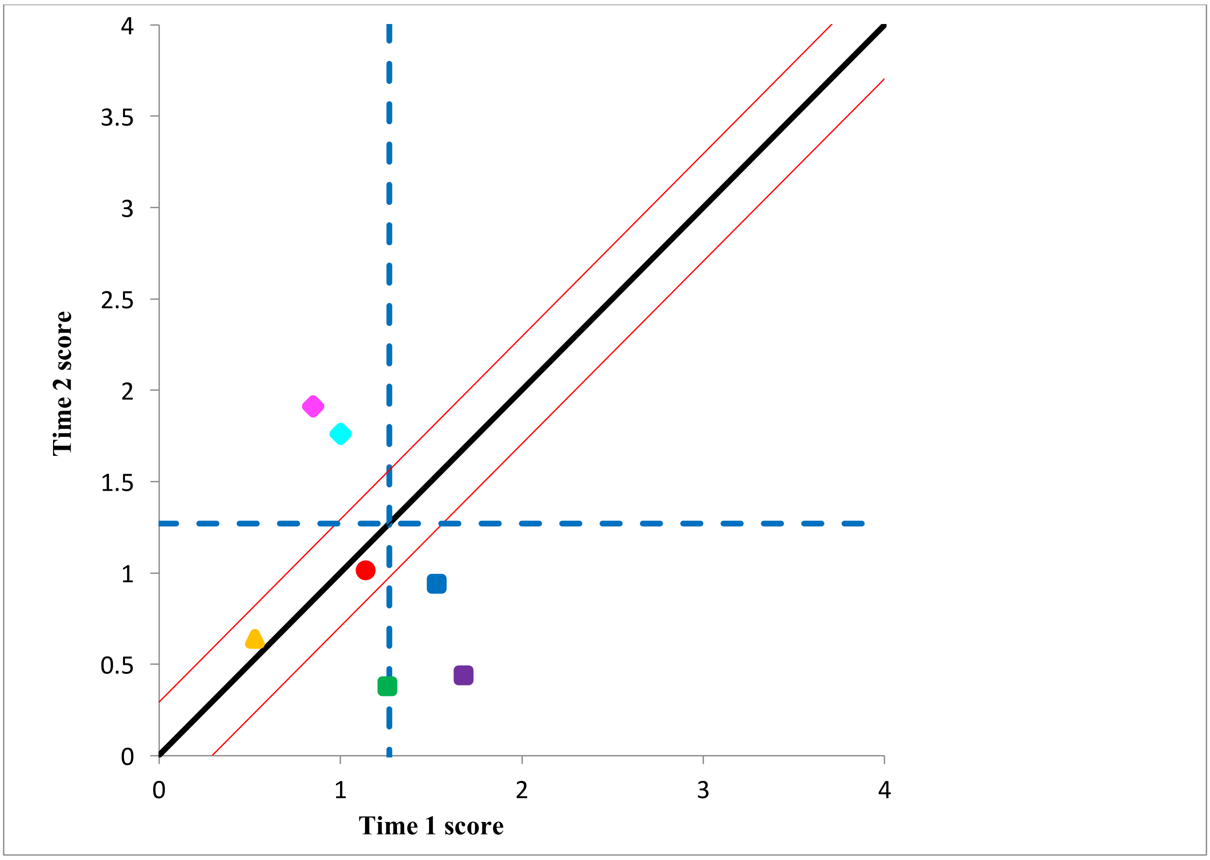

*Figure 3.4*: Graph showing participants time 1 and time 2 scores on the CORE-OM

Table 3.9

*Participant RCSC categorization for CORE-OM*

| Participant number | Graphic illustration | Category |
|---|---|---|
| M1 | ◆ | Deteriorated |
| M2 | ◆ | Deteriorated |
| M3 | ▲ | Unchanged |
| M4 | ■ | Recovered |
| M5 | ■ | Recovered |
| M6 | ■ | Recovered |

#### *3.2.2.2 MORS-SF.*

Participants raw scores on the MORS-SF warmth and invasion sub-scales at time 1 and time 2 are shown in Table 3.10. The duration between time 1 and 2 MORS-SF assessment for each participant is presented in Table 3.11.

Table 3.10

*MORS-SF raw scores*

| **Participant** | **Time 1** | | **Time 2** | |
|---|---|---|---|---|
| **number** | **Warmth** | **Invasion** | **Warmth** | **Invasion** |
| M1 | 28 | 23 | 32 | 10 |
| M2 | 8 | 7 | 26 | 12 |
| M3 | 32 | 11 | 32 | 8 |
| M4 | 32 | 2 | 30 | 2 |
| M5 | 24 | 5 | 31 | 8 |
| M6 | 27 | 8 | 35 | 14 |

Table 3.11

*Duration between time 1 and time 2 MORS-SF assessment*

| **Participant number** | **Duration between time 1 and time 2 assessment** |
|---|---|
| M1 | 1 year 3 months |
| M2 | 9 months |
| M3 | 8 months |
| M4 | 10 months |
| M5 | 6 months |
| M6 | 10 months |

Referential data from Coster, Brookes and Sanger (2015) was used for the MORS-SF RCSC. Coster et al (2015) used the MORS-SF in an evaluation of a group intervention using postnatal education and support targeting hard to reach parents. Their sample consisted of 138 mothers and the pre-intervention scores on the MORS-SF acted as referential clinical norms. For the non-clinical referential norms, a sub-sample from

Milford and Oates' (2009) research was used. In this research routine health visitors screened 207 mothers 6-8 weeks after giving birth using the MORS-SF. Mothers were categorized into groups of low, moderate, and high concern with the latter two groups requiring input supplementary to universal services. Data for the low concern group acted as the referential non-clinical norms. The resultant referential norms for the invasion scale are shown in Table 3.12, and for the warmth scale in Table 3.13.

Table 3.12

*Referential data for the MORS-SF invasion scale (sd = standard deviation)*

| **Source** | **Clinical** | | **Non-clinical** | | **Cronbach's alpha** |
|---|---|---|---|---|---|
| | **Mean** | ***sd*** | **Mean** | ***sd*** | |
| Coster et al (2015) | 12.10 | 6.30 | | | |
| Milford & Oates (2009) | | | 7.10 | 3.80 | |
| Oates & Gervai (2003) | | | | | 0.90 |

Table 3.13

*Referential data for the MORS-SF warmth scale (sd = standard deviation)*

| **Source** | **Clinical** | | **Non-clinical** | | **Cronbach's alpha** |
|---|---|---|---|---|---|
| | **Mean** | ***sd*** | **Mean** | ***sd*** | |
| Coster et al (2015) | 22.90 | 7.80 | | | |
| Milford & Oates (2009) | | | 25.40 | 5.50 | |
| Oates & Gervai (2003) | | | | | 0.90 |

For the PIMHS interventions to have improved the extent that parents perceived invasion by their infants, scores on the MORS-SF invasion scale were required to decrease. The CSC cut off according to criterion C is 8.98 indicating scores > 8.98 lie in the dysfunctional range and scores < 8.98, in the functional range. Figure 3.5 and Table 3.14 show the results of the RCSC analyses for participants and their categorical outcomes. Five parents (M2, M3, M4, M5, M6) are categorized as unchanged. However, four of these (M2, M4, M5, M6) had time 1 scores in the functional range. M1 is categorized as improved indicating reliable but not clinically significant change, with their time 2 score remaining in the dysfunctional range.

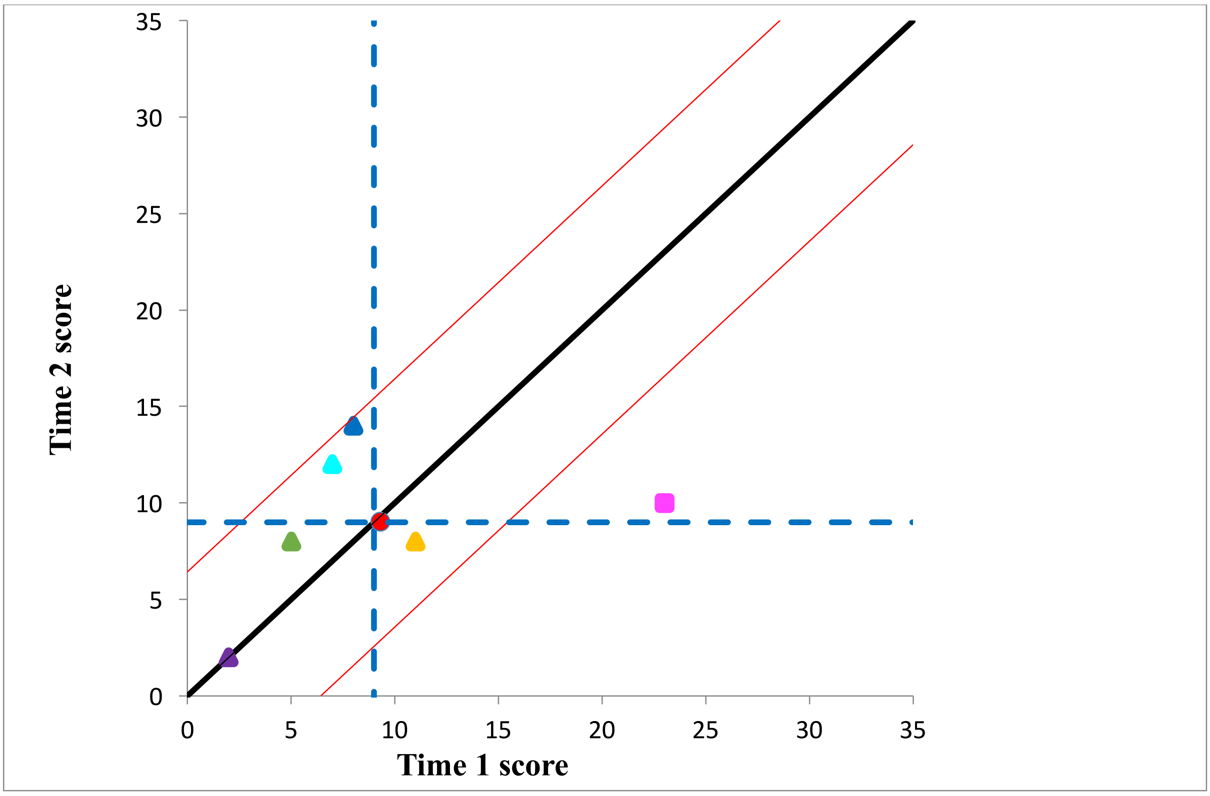

*Figure 3.5*: Graph showing participants time 1 and time 2 scores on the MORS-SF invasion scale

Table 3.14

*Participant RCSC categorization for MORS-SF invasion scale*

| **Participant number** | **Graphic illustration** | **Category** |
|---|---|---|
| M1 | ■ | Improved |
| M2 | ▲ | Unchanged |
| M3 | ▲ | Unchanged |
| M4 | ▲ | Unchanged |
| M5 | ▲ | Unchanged |
| M6 | ▲ | Unchanged |

For the PIMHS interventions to have improved the extent that parents perceived warmth from their infants, scores on the MORS-SF warmth scale were required to increase. The CSC cut off according to criterion C is 24.37 indicating scores > 24.37

lie in the functional range and scores < 24.37, in the dysfunctional range. Figure 3.6 and Table 3.15 show the results of the RCSC analyses for participants and their categorical outcomes. Two parents (M2 and M6) improved, with the remaining four categorized as unchanged. However, four participants' (M1, M3, M4, M6) time 1 scores were in the functional range, with M5's time 1 score just below the cut off for the functional range. All six parents' scores at time 2 were in the functional range.

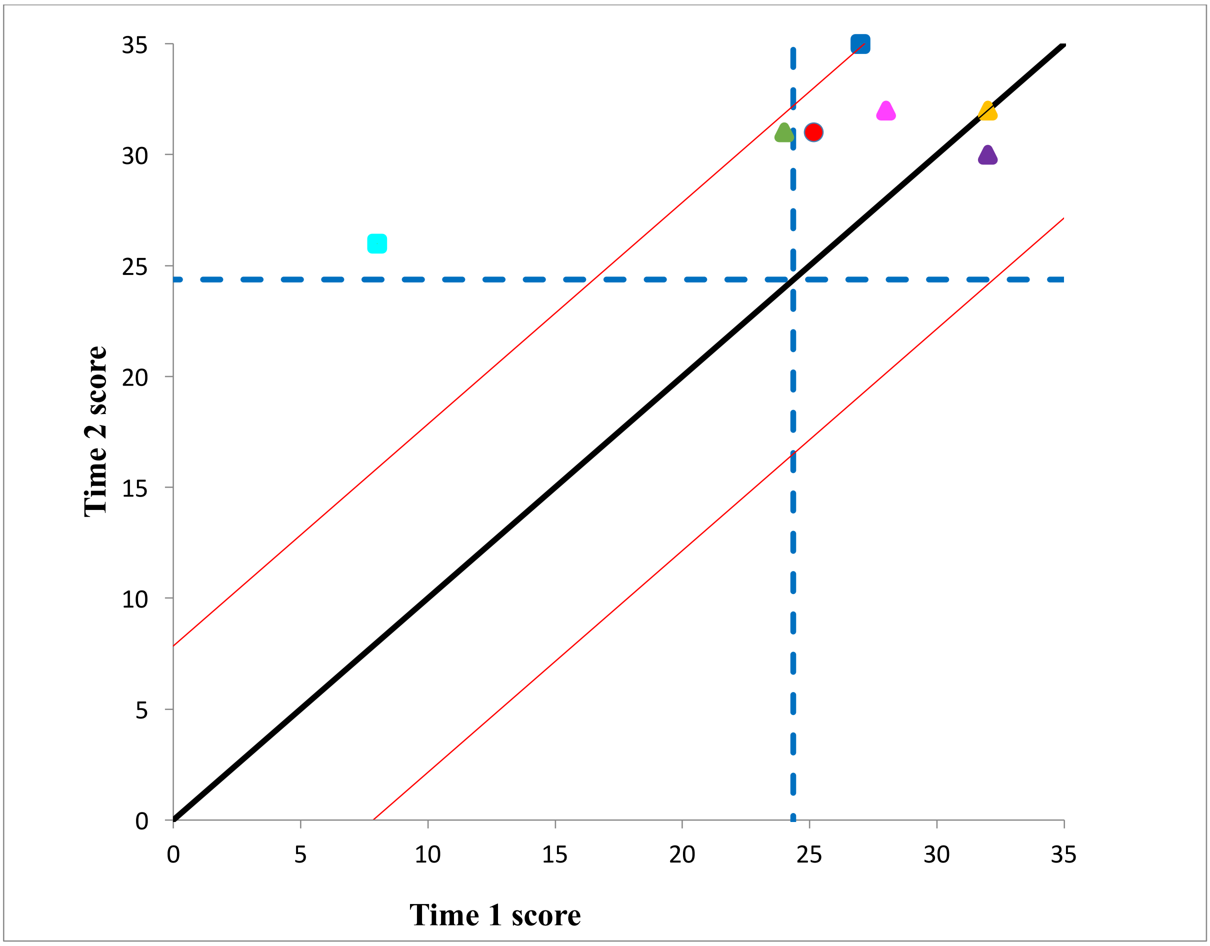

*Figure 3.5*: Graph showing participants time 1 and time 2 scores on the MORS-SF warmth scale

Table 3.15

*Participant RCSC categorization for MORS-SF warmth scale*

| **Participant number** | **Graphic illustration** | **Category** |
|---|---|---|
| M1 | ▲ | Unchanged |
| M2 | ■ | Improved |
| M3 | ▲ | Unchanged |
| M4 | ▲ | Unchanged |
| M5 | ▲ | Unchanged |
| M6 | ■ | Improved |

### 3.2.3 Descriptive and contextual changes.

Time 1 and time 2 PDI/MotC classifications of the parent infant relationship according to a dominant pattern and level of risk for each parent are shown in Table 3.16. The duration between time 1 and 2 assessments for each parent is shown in Table 3.17. Improvements in parent-infant relationships as represented through parental discourse obtained by the PDI/MotC would indicate a decreasing level of risk with, but not dependent on, a shift in relational pattern towards sensitive. At time 2 one participant (M6) was classified as adequate for risk, with a sensitive dominant pattern, indicating improvement. Reduced levels of risk were also indicated for a further three participants (M1, M3, M4) without accompanying changes towards a sensitive pattern. Two participants (M2, M5) showed no change, remaining classified as high risk.

Table 3.16

*PDI/MotC classifications*

| Participant number | Time 1<br>Risk | Pattern | Time 2<br>Risk | Pattern |
|---|---|---|---|---|
| M1 | High | Unresponsive/ controlling | Intervention/ Adequate | Unresponsive/controlling |
| M2 | High | Unresponsive/ controlling | High | Unresponsive/controlling |
| M3 | High | Unresponsive/ controlling | High/Intervention | Unresponsive/controlling |
| M4 | High | Unresponsive/ controlling | High/Intervention | Controlling |
| M5 | High | Unresponsive/ controlling | High | Unresponsive |
| M6 | High | Unresponsive/ controlling | Adequate | Sensitive (Unresponsive/ controlling) |

Table 3.17

*Duration between time 1 and 2 PDI/MotC*

| Participant number | Duration between time 1 and time 2 assessment |
|---|---|
| M1 | 1 year 6 months |
| M2 | 1 year 5 months |
| M3 | 1 year 2 months |
| M4 | 1 year 6 months |
| M5 | 1 year 7 months |
| M6 | 11 months |

Table 3.18 presents the time 1 (entry to the PIMHS) and time 2 (June 2016) safeguarding and service statuses. Section 47 accords to a child protection order and section 17 to a child in need order. Three parents (M3, M5, M6) are no longer under a court order and have been or are due to be discharged from the PIMHS. M2 has been reduced from a section 47 to 17 order, and M4 remains on section 47. In the case of M1 the infant has been removed under section 20.

Table 3.18

*Safeguarding statuses*

| Participant number | Time 1 | Time 2 |
|---|---|---|
| M1 | Section 47 | Section 20 (child removed) |
| M2 | Section 47 | Section 17 |
| M3 | Section 17 | Nil, discharged |
| M4 | Section 47 | Section 47 |
| M5 | Section 47 | Nil, due for discharge |
| M6 | Section 17 | Nil, discharged |

### 3.2.4 Individual changes across measures.

Looking across the set (Table 3.19), the results are mixed regarding both the extent that changes depicted by different measures accord with one another and that participants may be classified as having improved. In the case of M6 there is consistency, with all measures bar the MORS-SF (invasion) showing positive change, with M6's scores on the aforementioned measure being in the functional range at time 1 and 2. However, for example with M1 there is little consistency across measures. The measures assess differing constructs in different ways, with the CORE-OM and MORS-SF using self-report and the PDI/MotC using the interpersonal context of an interview coded blind by raters. Therefore, consistency across measures may not be expected. However, in the case of assessing risk there is a stark inconsistency between time 1 CORE-OM raw scores (all zero) and PDI/MotC classifications (all high). Although the PDI/MotC assesses relational risk, the CORE-OM also contains items to consider risk towards others. Thus more overlap might be expected. However, in addition to the small sample size, a number of limitations regarding the measures, their implementation and interpretability exist, to be discussed in the following chapter.

Table 3.19

*Change categorizations and statuses across participants*

| Participant number | CORE-OM | MORS-SF (invasion) | MORS-SF (warmth) | PDI/MotC risk (time 2) | Safeguarding status (time 2) |
|---|---|---|---|---|---|
| M1 | Deteriorated | Improved | Unchanged | Intervention/ Adequate | Section 20 (child removed) |
| M2 | Deteriorated | Unchanged | Improved | High | Section 17 |
| M3 | Unchanged | Unchanged | Unchanged | High/Intervention | Nil, discharged |
| M4 | Recovered | Unchanged | Unchanged | High/Intervention | Section 47 |
| M5 | Recovered | Unchanged | Unchanged | High | Nil, due for discharge |
| M6 | Recovered | Unchanged | Improved | Adequate | Nil, discharged |

## 3.3 Contextualising the thematic analysis with quantitative outcomes

The five main themes produced by thematic analysis captured four levels of relational context in which the fifth theme represented structural, interpersonal and mental practices that enabled clinician participants to process and expand understanding in their work. The RCSC analyses and descriptive changes for parent participants, compliment the thematic analysis in a number of ways. As captured by the sub-themes ‘parental ownership and recognition’ and ‘when the relationship is not enough’, the outcomes for the parents similarly depict both instances of change and no change. Indeed, the mixed nature of the outcomes for parents contextualises the heightened pressure that clinician participants alluded to within the sub-theme ‘oppressing’ regarding the need to obtain evidence and proof of their work.

The thematic analysis allows insight into the relational processes of the work that may influence outcomes in complex ways, and indicators of change that may not be captured by the measures. Captured by the sub-themes ‘having a space’ and ‘resisting’ clinician participants alluded to processes allowing parents to become open about ambivalence and difficulty in their situations and relationships. Relatedly, ‘therapy in a legal context’ captured the distrust and silence that parents might begin the work experiencing. These have implications for the extent to which time 1 assessments may reflect understandable parental reservations in reporting high distress. Likewise, through experiencing an acknowledgement and acceptance of difficulties and engaging in the reflective processes alluded to in ‘symbolizing’, time 2 assessments may be influenced by greater awareness and/or permission of distress culminating in scores indicating deterioration. Indeed, ‘parental ownership and recognition’ accords with such a scenario whereby clinician participants indicated placing great importance on parental insights and claim over both improvements and difficulties. However, the sub-theme ‘oppressing’ and main theme ‘professional positioning’ also captured the levels of structural and relational complexity in the work. The outcomes for parents indicating on-going difficulties similarly align with these.

# 4. Discussion

The discussion begins with a summary of the research findings, positioning them within relevant theoretical and research literature. A methodological critique follows, after which clinical and research implications are outlined. Researcher reflections are presented before the final conclusions.

## 4.1 Summary of findings

### 4.1.1 Thematic Analysis.

Thematic analysis addressed the primary research aim:

1) To explore the PIMHS clinicians' relational experiences with the mothers and infants they work with, and their reflections on therapeutic change

Five main themes were produced, which are discussed in turn followed by their conceptualization as inter-related domains of the work.

#### *4.1.1.1 The overbearing wider context.*

The overbearing wider context captured an experience of oscillation between oppression and resistance towards institutional and wider social contexts around the work. Clinicians discussed a resource-less context, uncertainty regarding physical stability and service permanence, and marginalization. These issues held a parallel applicability for the PIMHS and the families. The oppressive aspects of the wider context concerned a practical lack of service options and availability from the PIMHS, and financial and housing support for families. Associated with this were relational consequences. The lack of resources could directly threaten the integrity of the work, challenging clinicians' ethics, and straining relationships. The need for evidence and proof of the worth of the work and a rhetoric of longer-term financial savings was prevalent as a justification for the work, perhaps indicative of the adoption of wider institutional and societal imperatives implicitly prizing cost before care. The oppressive nature of the wider context was also resisted against. Primarily this appeared to be through acting as a proponent for community work, opposing medicalized labels and dominant, negative narratives regarding parenthood, championing ‘good enough’ parenting, and reifying examples of families who overcame expectations and difficulty.

Bell (2010) writes that the ‘marketization’ of health care can create a constant survival anxiety that without containment, cascades downwards through institutional systems with potential to undermine morale and charge workers to dictate care decisions based on budgetary concerns. This has applicability to the current findings, particularly in instances of clinicians considering whether supporting families less in need would enhance outcome evidence and thereby the service future. Such a scenario could lead to further marginalization of families in complex social and psychological circumstances, and raises questions for the renegotiation of care as central above cost. Indeed, the apparent conflict between advocating for marginalized families and the need for demonstrable outcomes evident in the findings is reminiscent of the bind of early intervention services noted by the Centre for Social Justice (CSJ, 2011). They raise that recommendations for services are contradictory, emphasizing a holistic approach to and focused on early-years intervention requiring shifts in culture, inter-agency working and skill level that is jeopardized by the apparent mandating of programmatic approaches. Furthermore, the CSJ (2011) call for re-consideration of hierarchies of evidence focused on the ‘effectiveness’ of interventions to the neglect of feasibility and appropriateness. They state that the methodology of programmatic approaches is designed to attract private investment and thereby requires defined outcomes for short-term financial returns. These should not be applied to investment decisions concerning broader social issues such as reducing inequality and establishing social and emotional wellbeing in young children that are unlikely to provide defined outcomes in short timescales (CSJ, 2011).

The backdrop of survival anxiety and uncertainty of permanence, of relevance to both the PIMHS and families, can be conceptualized as threats hypothesized in the attachment field to activate attachment processes thereby inhibiting the counterpart, exploration (Ainsworth, 1972). Hill, Fonagy, Safier and Sargent (2003) contrast two contexts of human behaviour. Situations of threat and challenge arouse affect and stimulate habitual modes of action and survival, whereas in conditions of minimal challenge uncertainty can be tolerated and exploratory and reflective processes enabled.

The overbearing wider context alludes to clinicians' experiences of oppression and states of resistance that suggest heightened affect and a felt sense of needing to take action. Hill et al (2003) state that the two kinds of activity are complementary, however in order to benefit from the new insights and understandings that stem from exploratory and reflective processes, a shared interpretative frame is required in which participants in a system collaborate and agree on the meanings of communications. As applied to the current research, it could be hypothesized that in order for the exploratory work of therapy to be enabled within a threatened wider context, there must be a sufficient shared interpretative frame in which inter-professional and professional-client communications are jointly agreed and understood.

#### *4.1.1.2 Professional positioning.*

Professional positioning explicated inter-professional processes and dynamics, and the challenges of a therapeutic position within a legal context. A central point of contention regarded binary conceptualizations of risk, in which mental health risk perspectives appeared to operate on a phenomenological understanding in contrast to social care perspectives associated with an objectivist stance that was relegated as a more simplistic and reactionary way of understanding by mental health participants. Of immediate importance to families, was acknowledgment that this created an unhelpful relativism through which the message to parents was that the safety or otherwise of infants may be a simple matter of opinion. Associated with polarized positions regarding risk, were instances of team splitting and an 'othering' of social care through which the threat of infant removal and ultimate responsibility for this seemed to become predominantly located within the social care profession. This raises questions for the function that this served, for example in preserving a therapeutic alliance by displacing blame away from parents and in compartmentalizing therapeutic and legal roles. The legal context raised ethical dilemmas for some regarding supporting a bond between parents and infants at the risk of this being broken, and in navigating between therapeutic and safeguarding roles. From clinicians' perspectives the legal context surrounding the therapeutic work held the power of silencing parents, distancing them from an ownership of being a parent, and creating an initial context of compliance and mistrust for which transparency acted as a bedrock of professional practice.

These findings provide a clinicians' perspective in accordance with literature highlighting the child protection proceedings context as challenging women's identity as mothers (Slembrouk & Hall, 2003), creating a silencing and mistrust (Broadhurst & Mason, 2013). In the context of working with clients with psychosis, Lorem and Hem (2012) reported that clinicians navigate a therapeutic alliance made fragile by having to alternate between care and restriction of clients. The current findings similarly allude to challenges for clinicians in operating between therapeutic versus safeguarding roles in the contexts of perinatal mental health and child protection proceedings.

The conflicting conceptualizations of risk and unhelpful relativism created are perhaps indicative of a lack of a shared interpretative frame of risk between mental health and social care professionals in the PIMHS. Without a shared frame as a common base from which to understand risk, participants in systems cannot be sure whether differences in how they think and feel are 'real' or whether they reflect failure to establish a shared frame (Hill et al, 2003).

#### *4.1.1.3 Dyadic/triadic relating.*

Dyadic/triadic relating alluded to connecting and distancing processes within the professional-parent-infant relationship. Here, the interpersonal context was the stage of therapeutic work. Participants described a trajectory of 'being with' families in which professional presence, persistence, acceptance, and ability to bracket professional agendas facilitated engagement in the face of parental ambivalence of help. Participants used the interpersonal context to be both witnessed by parents as trustworthy through engaging infants in play, and to witness and acknowledge parental insights and moments of love. However, distancing processes could also draw parents away from the interpersonal stage via physical non-attendance and withdrawal from open dialogue with professionals. Similarly, participants described pressures to withdraw from the relationship through parental coercion to reject. The potential for change was precluded when the therapeutic relationship could not withstand systemic pressures surrounding the parent-infant dyads, or resolve issues at a pace in keeping with the developmental timelines of the infants. Almost unanimously, participants described parental ownership and recognition as a marker of change. This alluded to ownership of being a mother, of difficulties, histories, and strengths. This self-understanding of parents appeared to pre-empt and enable action and lifestyle changes, potentially marking a shift from professional to parental responsibility for change.

The centering of the interpersonal context of change from which parents could reclaim an ownership of parental identities and recognize difficulties and assets, provides a clinician's perspective in line with research by Knudson-Martin & Silverstein (2009) highlighting interpersonal causes and remediation of post-natal depression from parents' perspectives. The pre-emptive force of parental self-understanding in enabling practical, observable changes in lifestyle accords with research indicating the emergence of agency in client narratives before symptomatic and functional changes (Adler, 2012) and advising cultivation of self-mentalization through therapy before other-mentalization (Suchman et al, 2010). This raises questions for the extent that outcome measures capture shifts in parental ownership, recognition and agency, and highlights a qualitative difference in what clinicians may hold as indicators of change from that of outcome measurement focusing on symptom/behavioural change.

#### *4.1.1.4 The self in the work.*

The self in the work provided perspective on participants' use of their personal selves in the work. For some, identification with parents through common experience appeared to enable empathy and knowing, where for others passion for the work protected against burnout. Personal and professional selves could take different perspectives on parental situations, with the former fostering understanding of risk taking behaviour but inevitably being trumped by the latter in aid of safeguarding. Prevalent was the impact of the emotive and high-risk work on participants as causing states of high arousal and anxiety. Participants described fear, sleeplessness, feeling emotionally drained and sad. Although some described becoming de-sensitized to the pain of families' experiences and outcomes of child protection proceedings over time, also prevalent were indications of a self-searching by participants looking for different outcomes for the families. Being open was discussed extensively and crucially with a sense of being more than a professional act. Here, participants intimated using their whole selves receptively and freely to experience the parents and remain mentally present. From this open position, clinicians themselves could experience and be moved by the therapeutic relationship. Commitment was similarly widely discussed as an imperative stance for the work, particularly in the context of parents who were felt to have been sidelined.

The receptive and open state and committed stance alluded to by participants are relevant to research with women experiencing perinatal mental illness and child protection proceedings indicating distrust of professionals (Broadhurst & Mason, 2013) and the prevalence of traumatic life events (Edge, 2011) hypothesized to disrupt epistemic trust (Fonagy & Allison, 2014). Commitment and openness seemed to reflect imperatives for engaging with parents and infants who may be considered hard to reach. Openness alluded to a therapeutic position of being available to parents, which it could be hypothesized facilitates clinicians to become accessible in an epistemic way to encourage parental trust. The self in the work points to a bi-directionality in the professional-parent relationships through which identification, passion and openness facilitate the work and could also be hypothesized to influence the extent to which clinicians are affected by the work as alluded to by references to states of anxiety by participants.

#### ***4.1.1.5 Connecting and expanding understanding.***

Connecting and expanding understanding explicated processes that allowed participants to make sense of and respond to the work across the conceptualized four domains. Descriptions of ‘having a space’ represented both a physical and mental arena in which clinicians could process pain and emotional responses to the work in an interpersonal context in supervision and the group forum. This process could then allow clinicians to be a space for families. Here, space could interrupt patterns of relational distress and invite subjugated parental feelings of ambivalence or hatred, which might otherwise remain hidden. The group forum could resolve splitting and ‘othering’ by providing a space to develop reciprocal professional respect and complimentary views, and supported the dissemination of research and knowledge. Engaging with research, literature, and training appeared to act as a powerful means of using knowledge to defend the PIMHS work, particularly in justifying timescales of the work against the backdrop of a resource-less context. However, in the context of raised anxieties for example regarding risk assessment, habitual professional ways of thinking appeared to prevail over a collective and shared understanding. Research and knowledge could provide a reassurance of therapeutic approaches and act as a form of professional betterment, with many describing a desire to learn more with a sense that these were powerful assets for individual professionals. Sharing literature could hold a rallying function in spreading the word to others. However, one participant alluded to a hierarchy of professional knowledges in which social care research and methods could be sidelined. Symbolizing and meaning making also appeared key in processing the relational contexts of the work. Coming to shared understandings with families and colleagues alike was a central aim and measure of the impact of the work and relational wellbeing.

Slade (2008) writes that much work is needed in order to translate the wealth of research literature regarding attachment and reflective functioning (RF) into clinical practice. Connecting and expanding understanding is suggestive of the utility and necessity of reflective space in the PIMHS in order for clinicians to process the emotional impact of the work and make iterative use of research and literature for clinical practice.

#### *4.1.1.6 Conceptualizing the inter-related domains.*

Bronfenbrenner's (1994, 1995) bioecological theory of human development has relevance in conceptualizing the main themes as inter-related domains. The process-person-context-time (PPCT) model (Bronfenbrenner, 2005) proposes that 'proximal processes' (for example one-to-one and group play, learning skills) drive development through reciprocal interaction between active agents and persons, objects and symbols in their environment over time. The nature and impact of proximal processes effecting development vary systematically as a function of the characteristics of the developing person, the environment (from immediate microsystem to wider cultures encompassing the macrosystem), the developmental outcome under consideration and the temporal context of the lifespan and historical period (Bronfenbrenner & Morris, 1998). Although Bronfenbrenner's theory evolved, an appreciation of person-context interrelatedness remained central (Tudge, Mokrova, Hatfield & Karnik, 2009). Within the attachment field, the applicability of ecological models to parenting has provided a framework for understanding interrelating interpersonal and environmental factors influencing parent-infant relationships (Farnfield, 2008).

As applied to the PIMHS and therapeutic change, an ecological frame accords with the interdependent and relational nature of the work alluded to by the current findings. The characteristics of clinicians captured by the self in the work allude to clinicians as active agents influencing the therapeutic relationship. Dyadic/triadic relating encompasses proximal processes through which clinicians draw on relational techniques and interactions with families in order to foster parental ownership and recognition in particular. Patterns of the therapeutic relationships and possibilities for therapeutic change were considered to vary as functions of the family, professional and wider environments. Bronfenbrenner (1995) considers that for proximal processes to be effective they must occur on a fairly regular basis over extended periods of time and that in unstable environments their effectiveness is reduced with corresponding disruptive effects on psychological functioning. Similarly, in the current research the pressures of a resource-less context captured by the overbearing wider context and instability of both families and the PIMHS alluded to disruption of the therapeutic work and strains on relationships. By conceptualizing the themes as interrelated domains with the fifth theme representing processes by which participants responded to their work, the role of the clinician, therapeutic and inter-professional relationships, environmental stressors, and wider contexts and values drawn upon by participants were considered influential to the PIMHS clinicians' experience of their work and their perspectives on therapeutic change.

### 4.1.2 Quantitative outcomes.

Reliable and clinically significant change (RCSC) calculations and descriptive comparison of contextual outcomes were used to address the secondary aim of the research:

2) To analyze quantitative outcomes for the mothers and infants engaged with the PIMHS using pre and post-intervention measures

The RCSC calculations provide mixed support for the extent that the parents and infants benefitted from engagement with the PIMHS. Analysis indicated three 'recovered', two 'deteriorated' and one remained 'unchanged' in terms of levels of functioning, symptoms, wellbeing and risk as captured by the CORE-OM. As measured by the

MORS-SF, two parents ‘improved’ in the extent that they reported experiencing warmth from their infants. Four remained ‘unchanged’, however all six had post-intervention scores in the functional range. One parent ‘improved’ regarding reports of invasion from their infant, with five ‘unchanged’. Comparisons of pre and post-intervention PDI/MotC classifications indicated that one parent improved to levels of relational risk considered adequate, while three parents reduced in levels of risk but remained at levels requiring further intervention. Two parents showed no change, remaining classified as high risk. Comparison of pre and post-intervention safeguarding statuses showed three parents were no longer under court order and were due for PIMHS discharge. One parent was reduced from section 47 to 17, one remained unchanged on a section 47, and one parent had an infant removed under section 20. Similar to the mixed levels of change, there was little consistency across the measures for the individual parents-infant dyads.

From an attachment perspective and the contribution of Crittenden’s (2005) Dynamic Maturational Model, the proposal that one individual’s intervention needs may be the converse of another’s may have relevance to the interpretability of the quantitative outcomes. The implications of directions of score changes may vary depending on the parental and situational context. For example, the high scores across the parental group on the pre-intervention MORS-SF warmth scale and no indications of risk on the CORE-OM could be indications of idealizing and minimization of difficulty for which increases in scores may represent a beneficial therapeutic outcome indicating a shift towards a realistic, permissive and open reporting of struggles and distress. However, divorced of this context a quantitative analysis would suggest a deteriorative outcome. Sleed, Baradon and Fonagy (2013) make a similar case suggesting high levels of idealizing at pre-intervention in a sample of mothers in prison may have influenced a lack of differentiation between treatment and control groups on the MORS-SF warmth scale. It is not possible to draw firm conclusions regarding the extent that the CORE-OM and MORS-SF may have been influenced by levels of idealizing and/or minimization of difficulty. However, particularly within the frame of the qualitative findings and complex circumstances of the families and work, the quantitative findings are illustrative of the context dependent interpretability of outcome measures and raise questions regarding the validity of the self-report measures in the current research.

#### 4.1.3. Contextualising the qualitative inquiry with quantitative outcomes.

In therapeutic practice collection and analysis of qualitative and quantitative data is routine (Frels & Onwuegbuzie, 2012). This aspect of the research intended to consider two forms of knowledge and stories of change that remain with services after client discharge, the views of clinicians and client assessment measures, to provide richer interpretations. Both methods indicated a complex, mixed profile of change for the parents and infants, offering legitimisation (Frels & Onwuegbuzie, 2012). Using two forms of inquiry drew attention to possible contradictions between the aims of therapeutic work according to clinicians and interpersonal indicators of change, in comparison to assessment of change through outcome measures. Clinicians alluded to working towards a permissive and open recognition of difficulty and resilience as pre-emptive markers of change that may be missed/misrepresented by measures such as the CORE-OM and MORS-SF. Relatedly, the qualitative component contextualises the quantitative outcomes, highlighting pressures to obtain evidence for the worth of the work and survival of the PIMHS. This provides insight into how much may be felt to rest upon measures, which may be open to misinterpretation particularly within small samples of families in complex circumstance where directions of positive effect are assumed to be the same across participants. The complexity of the relational and interdependent nature of the work highlights a dilemma in how best to consider the worth and success of the work.

### 4.2 Methodological strengths and weaknesses

A methodological critique is outlined for necessary consideration when interpreting the results and their implications. The section begins with reflections on the methodology focusing specifically on the use of qualitative and quantitative inquiries, before critiquing broader elements of the methodology.

#### 4.2.1 Reflections on the methodology.

##### *4.2.1.1 Justification and aims of the methodology.*

The current research employed the use of both a qualitative and quantitative component. In addition to the justifications of each component individually as discussed in the introduction and method chapters, the use of both together was considered beneficial for the following reasons. It was hoped that comparison and discussion between the two components could support hypothesis building with regards to factors that may be facilitative or detrimental to the process of therapeutic change in this context. For example, it was considered that through the qualitative inquiry clinicians may raise factors that could help to interpret and frame changes on outcome measures for instance if measures suggested symptomatic but not relational change, or vice versa. If there were predominantly deteriorations or improvements on the measures, might there be themes from clinician discussions that could support hypotheses as to the patterns of change on outcome measures? Using both components was hoped to allow an examination of whether clinicians' reflections and outcome measurement might align or differ in the descriptions that both provide of the work. With both inquiries included it was hoped there would be the possibility of exploring disconnections or corroborations between the two perspectives, for instance if clinicians' largely described successes of the work but outcome measurement suggested otherwise or vice versa.

With regards to the inclusion of multi-disciplinary and multi-agency clinicians, it was deemed important to have diversity of professionals across training backgrounds and levels of expertise as indicated by the systematic review and in order to reflect current clinical practice emphasising professional collaboration. It was hoped that an inquiry into relational experiences with parents in this context that reflected these multiple viewpoints might be illuminating as an area that has not been extensively researched previously. The implication of this, however, was that not all the professionals would have had a traditionally designated 'therapeutic' role or frame with the parents and infants. As such, an inquiry focusing in on the minutiae of dyadic one-to-one therapy was not thought to be appropriate given the diversity of clinical approaches with the families but rather a more general, naturalistic inquiry focusing on relational processes was. Including an array of professionals was considered to be in line with ecological systems theory and attachment perspectives (Bronfenbrenner, 2005; Farnfield, 2008), with an appreciation that professionals and processes at multiple levels of the context surrounding the parents and infants may influence the shape of their support in nuanced ways. As such, the inquiry took a broader view on the process of therapy than a one-to-one 'in the room' perspective on therapeutic process.

#### *4.2.1.2 Limitations of the methodology.*

Although the methodology allows a dialogue between the two components, as different methods of inquiry using different samples they do not overlap, and are therefore not easily comparable. The qualitative inquiry with clinicians provides information regarding general processes of the work, in comparison to the quantitative inquiry using psychological measures with the parents that provides information on specific outcomes in individual cases. Thus, the qualitative inquiry with clinicians does not provide qualitative information on demarcated, individual parent-infant dyads and trajectories of their therapy and thereby cannot provide insight into what was and was not significant in individual instances. To elaborate, it does not provide a thick description of how clinicians represent and make meaning of their relationships with specific parents and infants that could have been linked with the individual outcomes obtained through quantitative measurement. Instead what the approach used does provide is general process information regarding clinicians' array of experiences with the parents and infants with whom they have worked in the PIMHS, punctuated with specific examples to illustrate their experiences. Similarly, the methodology used does not benefit from the voice of the parents to consider their perspectives and reflections on the process of the work, which similarly could have explicated and been linked to their individual quantitative outcomes.

In considering the outcomes that were hoped to be achieved through the methodology used and the actuality of a very mixed and nuanced set of quantitative outcomes, the distinctness of the qualitative and quantitative components is more problematic. Had there been clear trends or patterns of improvement/deterioration within the quantitative component, it may have been possible to discuss these in relation to salient themes from the qualitative analysis that could contribute towards hypotheses for future research in a more straightforward manner. However, alternative methodologies would also have allowed the two components to be more robustly and conceptually linked.

#### *4.2.1.3 Alternative approaches.*

The following methodologies are suggested as alternatives to the current design, which could have provided the benefits of a mixed methods approach alongside a conceptual overlap between qualitative and quantitative components. One alternative would have been to interview clinicians regarding their specific therapeutic and working relationships with individual parent-infant dyads, rather than regarding clinicians' experiences more generally. This would have allowed a direct comparison between the outcomes for the dyads and aspects clinicians' discussed as salient in each case. Similarly, interviewing parents regarding their experiences of the work and relationship with clinicians would have allowed the resultant data to be triangulated with the specific parental outcome data. Using either or both of these approaches would constitute an in-depth case study design whereby phenomena are investigated in their real life context using multiple sources of evidence (Yin, 2009). Such an approach could have provided analytical, rather than statistical, generalization whereby patterns of findings may support theoretical views concerning potential mechanisms of therapeutic change at work and the contexts of their operation (Robson, 2011). This approach can be explanatory albeit for a small number of instances, by allowing a holistic description of phenomena through an iterative research process (Easton, 2010). As applied to the current research, a case study approach could have allowed a three-dimensional account of the work and explicated processes of the work that may lead to particular outcomes for the parents and infants.

A further alternative could have been to focus in on the relational processes of the work, rather than additionally consider quantitative outcomes. Interviews with clinicians using an adapted PDI framework could have been conducted focusing on their relationships with specific parents to provide information on the meanings and representations clinicians hold of particular parents and their work with them. Likewise, interviews with parents using an adapted PDI framework could have been undertaken to yield equivalent information regarding parental meanings and representations of their relationships with particular clinicians. Qualitative analysis and comparison across twinned interviews could have allowed examination of points of overlap and difference regarding what each considers salient in their unique, individual therapeutic relationships. This approach could have illuminated issues raised in the introduction regarding processes of avoidance, mistrust and silencing prevalent in perinatal mental health and child protection proceeding contexts with reference to nuanced, relational information.

### 4.2.2 Design.

The research employed mixed methods with a qualitative inquiry taking priority over a small n, quantitative inquiry. From a critical realist perspective, this provided a form of triangulation in which the two inquiries offered differed pieces of a jigsaw (Ussher, 1999) to gain a more complex but still partial understanding of experiences of the PIMHS work and therapeutic change. Employing both methods allowed a dialogue between the two inquiries as different perspectives on the same context and systematic consideration of points of corroboration (for example both indicating mixed experiences and outcomes) and contextualisation (for example illustrating that change in the process of the work may conflict with outcome measurement of change). The design intended to reflect real world practice to enhance ecological validity, paralleling the views of clinicians and the outcome measures that remain with services following client discharge. Use of both qualitative and quantitative inquiries was further indicated in the systematic review.

Although the qualitative inquiry provides insight into relational processes with the dyads in general, the comparability of the interviews and outcomes per dyad is a limitation, as discussed above. A further alternative to those suggested previously would have been to analyse for change on the measures for parents as a point of departure, to then select a stratified sample of cases of improvement, no change and deterioration. Interviews with clinicians regarding their relational experiences could then have been conducted for dyads within the sub-samples. This would have allowed more direct comparison between the qualitative and quantitative inquiries. However, the timelines of the PIMHS time two assessments and thesis, and the small sample size of dyads limiting stratification into sub-samples, did not allow for this.

### 4.2.3 Service setting.

The service setting brought strengths and limitations. The real world setting provided access to clinician participants regarding their perspectives on live, ongoing relationships with clients and colleagues and day-to-day work experiences, supporting ecological validity. For the parent-infant dyads, the naturalistic setting provided an ethical and ecologically valid approach, with all families offered assessment and intervention according to their individual needs and formulations. However, these same strengths can be recast as limitations. The small sample size and lack of control group preclude generalizability of the quantitative results. The non-standardization of assessment and intervention prohibit consideration of specific components of the support package as ‘active ingredients’ in cases of change. However, the research aims were not to evaluate efficacy of the PIMHS interventions. Employment of a randomized control trial design was beyond the feasibility of the research and identification of a comparison group with similar levels of complexity and legal circumstance that would not receive the support was not thought to be ethical. However, descriptions of the service context, operational approach, and characteristics of the clinician participants and parent-infant dyads provide contextual information to allow readers to assess the transferability of the findings to other contexts (Lincoln and Guba, 1985).

### 4.2.4 Sample.

Regarding clinician participants, there may be selection bias. All participants approached via expression of interest forms (15) did not necessarily participate, and responses are reflective of those who volunteered (10). Those who did not volunteer may have held different perspectives such that responses may not be representative of all views across the PIMHS. A potential limitation for transferability assessment is the restricted reporting of clinician participant demographics. This was an ethical decision based on the importance of promoting anonymity in the context of small service. One strength of the sample is the range of professional backgrounds of participants, spanning the multi-disciplinary team. This enabled a synthesis and analysis of inter-professional views with applicability to the current NHS context with its focus on multi-disciplinary working. The analysis did not delineate perspectives across professional subgroups. In light of the apparent discrepancies between professional perspectives particularly regarding risk it may have been beneficial to analyse across professional subgroups and compare resultant themes. However, the sample size did not allow for this and social worker perspectives were underrepresented in numbers. Relatedly, the outsider positioning of social care alluded to in the analysis held relevance for recruitment and sampling, with limited availability of social workers at PIMHS meetings during recruitment. Approaching social workers involved with the PIMHS at their base may have been beneficial in widening access to their perspectives. However, this was not anticipated and arranged for in ethics approval processes.

The strength of the real world sample of parent-infant dyads lies in its' ecological validity, whereby the complexities of the families did not exclude them from the service and research, which may enhance its applicability to real world practice (Song et al, 2010). In the context of research seeking to evaluate standardized interventions for specific disorders, the sample would pose threats to internal and external validity and limit generalizability. As the aim of the current research was to use quantitative outcomes to contextualize and complement the qualitative inquiry, the complexities of the sample are accommodated. Parent-infant sample demographics, referral contexts and intervention details were reliant on liaison with PIMHS professionals and not confirmed by parents. This was in accordance with ethics approval to maintain family anonymity from the researcher, however a limitation is the incomplete information regarding levels of education for two parents.

A crucial limitation is the missing voice of the parents. The extent to which the findings from the qualitative inquiry reflect the experiences of the parents is unknown. Parent contributions would have increased rigour and trustworthiness of findings by allowing comparison to clinicians' perspectives and explication of the quantitative outcomes. The parents were not approached for interview in appreciation of the demands of their current health and legal circumstances and substantial contribution through the outcome assessments. The supplementary requirements of being interviewed were considered to be unjustified.

### 4.2.5 Measurement issues.

#### *4.2.5.1 Interview schedule.*

A virtue of semi-structured interviews with open-ended questions is that they allow unanticipated themes to emerge (McEvoy & Richards, 2006) and access to tacit clinical intuition guiding practice (Silverstein et al, 2006). Using the framework of the PDI for the interview schedule was considered beneficial as an established assessment allowing information on current and evolving relationships (Slade, 2005). The purpose of using the PDI as a framework was to engage clinicians' broad representations of the relational work from an appreciative position of the questions' intention to stimulate reflections on relationships. The interview purpose was not to, and thereby does not, assess clinicians' levels of reflective functioning as per the RF scale, prohibiting comparison to research using the RF scale.

The inherent interpersonal context of the interviews can have consequences for clinicians' willingness to disclose strong personal or difficult responses to their clients (Hayes et al, 2015) and/or colleagues. However, the analysis alluded to deeply felt personal and professional reactions to the work indicating a degree to which this potential was minimised. Field notes were used to provide a non-verbal outlet for participants to express their experiences of the interview process. Unanimously these indicated a comfortable experience, further allaying this concern. However, one participant reflected that they had been concerned about discussing the extent of inter-professional conflicts for fear of detrimental impact to the perception of the service. Although this highlights the utility of the field notes, it is possible the professional conflicts captured by the analysis were minimised. It also raises questions for participants' perceptions of the researcher, discussed below.

Although through orientation and interest participants were familiar with attachment and RF literature, the interview began with a broad statement inquiring about clinicians' relational experiences and no definitions of particular phenomena were provided. Similarly, the interview sought to balance inquiry about positive and negative experiences in the work, lacking in the systemically reviewed studies. These aspects capture a strength of the interview in seeking an exploratory, rather than confirmatory, inquiry.

#### ***4.2.5.2 Quantitative measures.***

The use of secondary, routinely collected outcome data was an ethical strength in not disrupting normal service activity for families and maintaining family anonymity from the researcher. However, this was at the cost of researcher control over measure selection and implementation procedures. The duration between time 1 and time 2 assessments differed between parent-infant dyads and across measures. Although this may reflect real, practice-based use of outcome measures, it has implications for interpretations of change across the set. Longer intervals between assessments may allow for greater change to occur or conversely could allow for greater scope to capture deterioration associated with life events as alluded to within the sub-theme ‘when the relationship is not enough’. This limitation could have been reduced by use of a minimum of three assessment time points which would have allowed for assessment of stability of change, retaining the focus on individual rather than group change whilst enhancing the reliability of the change categorizations for the parents. This may be important feedback for the service in their on-going work, to balance against the further time and effort multiple assessment time points would require of the clinicians and parents.

A strength of the set of measures is their coverage of both dyadic and relational (MORS-SF and PDI/MotC) as well as symptomatic and functional (CORE-OM) issues. Descriptions of changes in safeguarding statuses further contextualize the outcomes for families. The set provide both self-report (CORE-OM and MORS-SF) and professional (PDI/MotC and safeguarding statuses) perspectives, providing complementary forms of outcome enhancing credibility.

The phrasing of the MORS-SF questions towards infant behaviour rather than parental perception is assumed to minimise social desirability bias (Davies et al, 2008). However, studies (Simkiss et al, 2013; Davies et al, 2008) have reported negative and positive skew on the warmth and invasion scales, respectively, suggestive of social desirability bias. Relatedly, the extent that the MORS-SF is sensitive to change and able to discriminate between clinical and non-clinical groups has been questioned by reports of large standard deviations and no statistically significant change following intervention on warmth (Sleed et al, 2013) and invasion scales (Sleed et al, 2013; Coster et al, 2015; Coe and Barlow, 2013). These raise questions for the construct and discriminant validity of the MORS-SF and hence interpretability of the RCSC categorizations, particularly in light of four parents obtaining time 1 scores in the functional ranges for both warmth and invasion scales. Indeed, the thematic analysis alluded to parental initial mistrust and a process of creating a permissive context to express parental ambivalence. The MORS-SF may not be a robust measure to employ in the context of high-risk families experiencing child protection proceedings where there may be understandable but pervasive parental concerns regarding expressing parenting difficulties.

Although a strength of the PDI/MotC is its' relational focus and interpersonal context, as a new coding system with insufficient psychometric data to assess reliability and stability over time it was a limitation that the resultant data were not amenable to RCSC. This likewise impacts on the interpretability of changes in classification from pre to post-intervention. However, the classifications of relational pattern and risk allow a qualitative description of relational change and as an outsourced clinician-rated assessment it benefitted from blind coding and reduced potential for associated researcher bias. Similarly, comparison of pre and post-intervention safeguarding statuses compliment the measures in providing a professional perspective and assessment of parental change in terms which have immediate and important consequences for the families.

### 4.2.6 Analyses.

#### *4.2.6.1 Thematic analysis.*

Thematic analysis provided a suitable analytic method for the qualitative data with theoretical flexibility enabling compatibility with the critical realist epistemology of the research (Braun and Clarke, 2006). The six stages of analysis outlined by Braun and Clarke (2006, 2013) provided a scaffold for the analysis, enhancing trustworthiness and replicability of the analysis. Using MaxQDA software enabled a systematic approach from which to review themes, codes and transcripts to assess attention to deviant cases and coverage of the data in line with recommendations to maintain quality (Crinson, 2001; Braun and Clarke, 2006). MaxQDA further maintained accessible links across themes, codes and raw data, and provided excel extracts to support the audit trail, enhancing analysis transparency. Sensitivity was strengthened by contextualising the analysis within attachment and RF theory and literature, being mindful of the local and wider contexts of the PIMHS, and attempting to minimise imposition of the researcher's own meanings on the data by keeping a reflective log (Yardley, 2008). Reliability checks were performed by an independent assessor, enhancing reliability and verifiability. Member checking of the analyses would have improved validity and credibility of the findings, although this procedure accords more with realist epistemologies seeking to establish the 'truth' of findings (Braun and Clarke, 2013). The reflexive stance, open ended interview questions and field notes allowed 'member reflections' (Tracy, 2010) during the research procedures albeit not regarding the findings.

#### *4.2.6.2 Reliable and Clinically Significant Change (RCSC).*

A strength of RCSC calculations is in establishing the clinical relevance of individual change during therapy (Ogles, Lunnen & Bonesteel, 2001) against socially valid criteria through referential population data (Evans et al, 1998). The calculations benefitted from the use of referential data obtained with large sample sizes, and for the MORS-SF of comparable demographics and context as recommended by Evans et al (1998). Lunnen and Ogles (1998) argue the JT-method may be too conservative, demanding excessive change to meet RCSC criteria. The related assumption of bi-modal distributions of clinical and non-clinical populations can be ameliorated by use of borderline or sub-threshold data for non-clinical referential norms (Lunnen & Ogles, 1998; Evan et al, 1998). Use of Milford and Oates (2009) data from a 'low concern' group of mothers strengthened RCSC calculations for the MORS-SF by allowing comparison to a group not necessarily entirely asymptomatic, in an attempt to capture meaningful, without requiring excessive, change. This may be particularly relevant in the context of families experiencing complex circumstances such a child protection proceedings and perinatal mental illness and the current qualitative findings highlighting 'good enough' parenting. The value of holding families and supporting psychological stability in challenging contexts may be lost in RCSC classifications of 'unchanged'.

A further limitation is that participants scoring higher in dysfunctional ranges at time 1 need to show greater changes in scores to meet CSC than those beginning with lower scores (Lunnen & Ogles, 1998). This may apply to the current research where on the MORS-SF warmth scale, M5 and M6 are categorized as 'unchanged' and 'improved', respectively, despite score changes differing by only 1 point. As discussed above, there is the possibility of skew due to social desirability bias on the MORS-SF and ceiling and floor effects demonstrated by the predominance in the current research of time 1 scores in the functional ranges. Caution is therefore required when interpreting the

RCSC calculations for the MORS-SF as it is not known what the effect of non-normal distributions and floor and ceiling effects have on these calculations (Evans et al, 1998).

#### 4.2.7 Researcher bias.

Knowledge systems of the researcher may act as filters (Henderson & Baffour, 2015), affecting the formulation of research questions and design, conceptualization of codes, theme development and interpretations of data (Braun & Clarke, 2013). Formulation of the research developed through an interest in attachment and RF theory and parent-infant relationships, and as a trainee clinical psychologist a curiosity in the process of providing therapy. Discussions in research supervision supported my awareness of wanting the research to be of use to the service and families, and the resultant potential for this to manifest as a bias towards positively interpreting the data. Supervision helped maintain my grounding in conducting the research from an independent, academic position to support neutrality. As a trainee psychologist with an interest in the field of work of the clinician participants, I intended to balance an outsider position with an appreciative perspective to facilitate openness. My outsider position to the PIMHS and independence from the intervention and delivery of outcome measures minimized potential researcher bias affecting parental responses, scoring of measures and quantitative data analysis. I attempted to maintain awareness of power differentials during the interviews (Braun & Clarke, 2013), both the possibility of my perception to interviewees as an ‘evaluator’ which might inhibit them, and whilst interviewing clinicians of senior status and experience to me the potential for myself to become inhibited. In the context of participants discussing splitting, it was important to maintain a neutral stance, facilitating openness in the conversation without aligning with different positions. Use of the semi-structured interview guide also aided this process in providing a framework for progression with designated areas of inquiry. The reflective log I kept throughout the research processes, thesis supervision and drawing on my clinical skills supported reflexive awareness of my leanings and acted as safeguards in order to balance my responses to participants to promote a net effect of maintaining a neutral position (Tomm, 1987). As discussed above, precautions were taken to ensure a transparent, systematic and sensitive thematic analysis with attention to positive and negative experiences embedded in the process as indicated through the systematic review.

The strengths and particularly limitations discussed need be taken into account when considering the subsequent implications of the findings.

## 4.3 Clinical implications

An overarching clinical implication of the current findings is of the multiple influences described by participants as affecting the work and potential for change spanning institutional, inter-professional, therapeutic and personal domains. NICE guidelines (ng26, 2015) recommend that in the context of attachment work with children in or at risk of going into care the stability of surrounding health, educational and social care structures should be ensured. The guidelines focus on management systems, collaborative decision-making and consistent professional involvement. The overbearing wider context theme alluded to a parallel uncertainty of permanence and stability for the families and PIMHS itself. An implication of this is that the reality of cuts to public services may place services at odds with practice guidelines and the potential need for guidelines to additionally consider the stability of professionals' working context that enable professionals to be a consistent presence for families. Relatedly, integrated, multi-agency working is recommended (Lagan et al, 2009; DoH, 2009; NICE ng 26, 2015) in supporting marginalized women in the perinatal period. The current findings attest to challenges within the PIMHS in establishing a shared conceptualisation of risk between mental health and social care professionals and the utility of an interpersonal, group forum in fostering complimentary views and approaches. In applying Hill et al's (2003) concept of the importance of a shared interpretative frame to the current findings, the implication from a phenomenological understanding of risk as described by mental health participants was that risk of harm may reduce through parental ability to verbalise thoughts to harm. In contrast, the objectivist stance associated to social care practice by participants was described as viewing utterances of thoughts to harm as indication of intention and therefore increased risk. Thus the equivalent scenario could potentially lead to different courses of action and implications for parents. The findings suggested this context created mixed messages for parents, which could understandably influence parents' decisions regarding expressing and exploring concerns. Thus the lack of a shared understanding and agreement of communications of risk appeared to impact on the therapeutic process. Relatedly, dialogue between service-users, practitioners and researchers regarding perceptions of risk has been called for in the context of early intervention services (Little, Axford & Morpeth, 2004). The practice implication of this may be in promoting the importance of and safeguarding inter-agency reflective space in order to familiarise with and explore different professional understandings and knowledge bases to minimise potential splitting with its associated consequences for parental understandings regarding assessment of risk and indications of safety.

Regarding the conceptualisation of inter-related relational domains of the work, an implication may be to consider the utility of working within different ecological domains. The conflicting timeframes of parental change and infant development, prevailing rigid narratives of parenting and silencing and distrust created amidst the legal context may suggest value in offering consultation regarding the processes of therapeutic work to legal and affiliated professionals. Such an approach may extend Hill et al's (2003) notion of establishing a shared interpretative frame to the wider context, potentially fostering greater agreement and understanding regarding the challenges and timescales of the work.

The findings suggest the work can have a significant emotional impact upon the clinicians, arousing states of anxiety and searching. Clinicians made connections between having a space for themselves through supervision in order to provide a space for families. A related implication is that perhaps particularly in perinatal mental health and child protection contexts, supervision should be protected across professional disciplines in order to maintain the openness, commitment and ability to bracket professional agendas that clinicians alluded to as imperative in engaging the families. Models of supervision predominantly link theoretically with specific forms of professional practice to encompass teaching of particular modes of therapy (Beddoe & Davys, 2016; Holloway, 2014). In relation to the current findings supervision drawing on bioecological, developmental and attachment theories and understanding would be appropriate. A related issue is that models of supervision integrating such understandings for services supporting infants and families are lacking (Finello & Poulsen, 2012). However, the 'mediated activity system' model (Engestrom, 1987) considers human action within multiple and changing contexts and relationships (Karvinen-Niinikoski, 2004). It holds a parallel to ecological theories whereby 'activity systems' comprise dynamically-influencing spheres of the individual, collectives, wider communities and shared symbols engaged in particular activities and has been applied for use in supervision and professional self-reflexivity (Karvinen-Niinikoski, 2004).

The findings indicate interplay between personal, relational, and collective levels in influencing the processes of the work and therapeutic outcomes. It may therefore be important to further consider the impact of systemic pressures on families that were suggested to preclude therapeutic change. To this end, incorporating the structures surrounding the parent-infant relationship in interventions and the professional structures around clinicians may be helpful. Similarly, consideration of the clients' identities as parents and recognition of their resilience as well as struggles may be beneficially supported at family and systemic levels, where possible and with parental consent, through engaging relevant systems in interventions more directly.

In appreciation of the limitations discussed above, it is difficult to make firm conclusions and associated implications regarding the quantitative outcomes. The broader context of qualitative inquiry suggests there may be multiple reasons, including the efficacy of the intervention, for demonstrations of change or no change on outcome measures. Particularly regarding the MORS-SF, consideration needs to be given in the selection of outcome measures for the purposes of evaluating perinatal mental health interventions in the context of child protection proceedings. Where there may be understandable parental reservations in reporting difficulties, incorporating clinician rated measures may be indicated. Although the PDI/MotC offered this, as a new measure insufficient psychometric data prohibit firm conclusions from its use. The extent that the outcome measures function cohesively as a battery also complicates the possibility of drawing conclusions on which parents have benefitted and in what respects. According to the outcome measures, the individually tailored, long-term interventions offered by the PIMHS appear to have benefitted some of the parents and not others. A clinical implication of this may be in the value of conducting pre and post-intervention interviews with parents and families to explore who may be likely to benefit from PIMHS intervention and their perspectives on what was and was not helpful. This would additionally aid in formulating approaches that may be better suited to the needs of those who did not benefit. In cases demonstrating deterioration or no change, on-going assessment using RCSC calculations may also benefit clinical practice in highlighting these cases in order to consider re-formulation of support.

### 4.4 Research implications

The current research does not detail the necessary or sufficient conditions for therapeutic change in a PIMHS context. Rather, through incorporation of an ecological perspective it can provide conditions to consider (Belsky, 1980) based on the perspectives of PIMHS clinicians complemented with outcome measurement. From both an ecological systems approach and a critical realist perspective, the identification of mechanisms and causal explanations, for example of therapeutic change, requires exploration of the dynamic relationships between agents and structures (Belsky, 1980; Easton, 2010). As above, the current findings attest to interplay of personal, relational, and collective factors that influence clinicians' experiences of the work and therapeutic change. Research and literature outlined in the introduction chapter similarly allude to factors spanning parental attachment histories and RF capacities (Belsky, 2005; Fonagy & Luyten, 2009), interpersonal relationships (Knudson-Martin and Silverstein, 2009), and social disadvantage (Edge, 2011) of relevance to engagement and therapeutic change in perinatal mental health contexts. Further research investigating the relationships and interactions between levels of the conceptualized inter-nested domains with multiple stakeholders is warranted. Research investigating experiences of PIMHS interventions and therapeutic change from parents' perspectives would be invaluable in explicating potential overlaps and discrepancies with clinicians' views on factors that enable or hinder change. Such research could be informative for instance in considering whether parental ownership and recognition of strengths and difficulties is similarly described by parents as an important marker of change and whether clinician attributes regarding receptiveness, openness and commitment are likewise described by parents as important for engagement. Furthermore, widening the research inquiry to legal professionals regarding their perceptions of mothers experiencing perinatal mental illness and child protection proceedings could be informative given the findings indicating mistrust and prevailing negative narratives of parents in the legal context. Engaging multiple stakeholders to consider their experiences of perinatal mental health services and processes of change could additionally enable 'catalytic authenticity' (Guba & Lincoln, 1994), building the capacity of systems to act (Henderson & Baffour, 2015), for example through widening a shared interpretative frame (Hill et al, 2003) of perinatal mental illness and timeframes for change.

The National Collaborating Centre for Women's and Children's Health (2010) poses the question of how to assess different service models aiming to support pregnant women with complex social factors. The current findings suggest it may be informative for evaluative research in the area of perinatal mental illness to include data collection regarding provision of clinician supervision and shared inter-disciplinary reflective space in the assessment of services and in relation to therapeutic outcomes. The current findings suggest these were vital spaces enabling clinicians to be receptive to families and as a forum to resolve inter-professional dilemmas. It may be possible to hypothesize that provision of these forums in perinatal mental health contexts may correlate with clinician and team wellbeing, and outcomes for families. Similarly, it may be illuminating for evaluative research regarding perinatal mental health services to incorporate data regarding the stability and permanence of the service, with current findings alluding to clinician anxieties stemming from the instability of the service. From an attachment perspective, theoretically it may be possible to hypothesize that service stability may indirectly support the exploratory work of therapy through enabling a secure base (Bowlby, 1988) for clinicians.

Large scale research is required to investigate the efficacy of longer-term, individually-tailored and multi-faceted interventions provided by perinatal mental health services to parents experiencing perinatal mental illness and child protection proceedings. Use of suitable control groups for example receiving shorter-term, manualised interventions is required to address questions regarding the possible benefits and cost effectiveness of longer-term and bespoke input. The current findings suggest use of both self-report and clinician rated outcome measures is warranted in such research. Relatedly, an overarching question remains how best to measure the worth of the work given the complex interplay of factors alluded to by the current findings. Research is needed to establish and investigate possible batteries of measures for use in perinatal mental health and child protection proceeding contexts to consider the measures complementarity and coverage of targets for change. However, as discussed above it may be beneficial to incorporate formulations of the work around the measures to support their context-dependent interpretability. Similarly, it may be useful for future research to specifically triangulate forms of evaluative assessment such as self-report measures with clinician-rated interview measures such as the PDI and AAI. Such an approach could advance understanding of the validity of self-report measures in the context of perinatal mental health and child protection proceedings contexts. Use of a critical realist epistemology for such research may provide a valuable orientation in its account of complex, co-determining events and compatibility with qualitative and quantitative inquiries. Furthermore, a critical realist stance may be beneficially applied in the context of child maltreatment to reconcile insights from objectivist and constructivist positions through its attentiveness to both structural tendencies and individuals' meaning making as giving rise to situations involving risk (Houston, 2001a & 2001b).

### 4.5 Researcher reflections

As I reflected over the processes of the thesis and training, I was struck by a sense of the centrality of families for me, both as an ongoing area of professional interest and of having formed and been supported by relationships that enabled a familial connection. As an outsider to the PIMHS, I was aware of visiting what felt in ways like a family, and felt moved by accounts of the work with the parents and infants. The reflective log allowed an initial and personal sounding board to voice these reactions and have them reflected back to me on the page. As well as a method through which to become more conscious of the potential ways these responses might create bias, for instance in manifesting as protective and overly positive interpretations of the data, the process supported my awareness of the anxieties and uncertainties I felt in developing a thesis. For me the process required an emotional encounter with feelings of inadequacy and a fear of approaching exposure through submitting chapters, the thesis viva, and dissemination. I have considered an extent to which holding onto the thesis has been an attempt to delay its judgment. To this end, the concept of 'good enough' parenting and outcomes resonated in my efforts to produce a 'good enough' thesis. This experience cemented the importance of safeguarding time and strategies to process the emotional impact of training and practice going forward (British Psychological Society, 2006).

As a specialist service embedding inter-agency working, conducting the thesis within the PIMHS stimulated my thinking regarding the utility but also great challenges of integrating and offering a cohesive service through inter-disciplinary and inter-agency working. It provided an understanding of the need to explicitly discuss and explore different frames of reference that can stem from professional trainings which ultimately resonate in encounters with clients. The marginalization alluded to regarding both the PIMHS and families, and evident in the research literature, gave me cause to reflect on the role of professionals in advocating for inclusion and equality in wider, societal contexts. The opportunity to consider this closely through the thesis has enhanced my commitment to community practice and desire to engage in practice that acknowledges socio-political contexts.

Engaging with ontological and epistemological frameworks was an intimidating yet significantly valuable process. In the context of my professional journey with a background cognitive neuroscience research, I became aware of having rarely truly considered my position in relation to research and of having unknowingly researched primarily from a positivist position. As a novice to critical realism and the application of mixed methods, I felt at times overwhelmingly concerned with how the qualitative and quantitative aspects could be integrated. Supervision was relieving in halting my cyclical revisions to the thesis proposal and thinking regarding balancing the length of time of interviews with the need for overlap with the quantitative data. Similarly, as a novice to qualitative research, I have considered the extent to which incorporating a quantitative component acted as a safety net and reflected my own internalised beliefs regarding hierarchies of knowledge and methodology. This component also seemed to resonate with the findings related to pressures on the PIMHS to demonstrate ‘observable’ outcomes. To this end, I struggled in interpreting the mixed nature of the outcomes for the parents and found reassurance in being mindful of the complexity of the context, and thereby assessment of it, and always of the ongoing iterative purpose of further research.

## 4.6 Conclusions

In conclusion, the research highlights the multifaceted nature of relational experiences of clinicians working within the PIMHS through which wider contextual, inter-professional, dyadic/triadic, and intra-professional factors resonate and impact upon the processes of the work. The themes attest to relational consequences for parents and infants of a lack of resources and marginalization, and underscore professional divisions with resultant mixed messages for families that may stem from polarized conceptions of risk. The findings suggest the importance for clinicians in taking an open, receptive and committed stance with families among parental ambivalence of help and expectations of rejection. Facilitating and witnessing parental ownership and recognition of difficulties and strengths appeared to act as a marker of change, with systemic pressures on families described as prohibiting change. The findings indicate a significant emotional impact of the work upon clinicians, for which identification and passion acted as motivating forces for clinicians. Engaging with research and literature, and having an interpersonal space in which to process and share understanding of the work appeared vital in responding to the complexities of the work.

The quantitative results indicated a mixed profile of the extent that parents benefitted from the PIMHS. In the context of little consistency across outcomes for the parents, the complex interplay of factors affecting the work according to clinicians holds consequences for the interpretation of the outcomes. The degrees to which the context and processes of the work influence measurement scores and interpretation, and the ability of the measures to function cohesively as a battery are important areas for further research. Nonetheless this component complimented the qualitative inquiry to indicate a nuanced picture of therapeutic change in this context.

The real-world setting and associated lack of control over parent sample size, assessment procedures, interventions and lack of control group prohibit generalization of the quantitative results and causal identification of ‘active ingredients’ of the intervention. However, details of the service, interventions and parental contexts provide information that can allow readers to assess the transferability of findings, and methodological procedures were followed to increase the sensitivity and trustworthiness of the findings.

The implications highlight a need to safeguard inter-disciplinary reflective space to consider professional frames of reference, and the possible utility in more directly engaging systems around the families and professionals, including legal colleagues, to share understandings and consider obstacles to the work. Research with multiple stakeholders, and particularly parents, regarding perceptions and experiences of perinatal mental illness and associated interventions would be invaluable in providing a more holistic understanding of the processes of change. Evaluative research in perinatal mental health contexts may benefit from consideration of the stability and permanence of services, and supervision and inter-disciplinary reflective space as possible facilitators of the work. Large scale research is required to establish the efficacy of longer-term, individually tailored interventions in supporting the permanence and development of parent-infant relationships.

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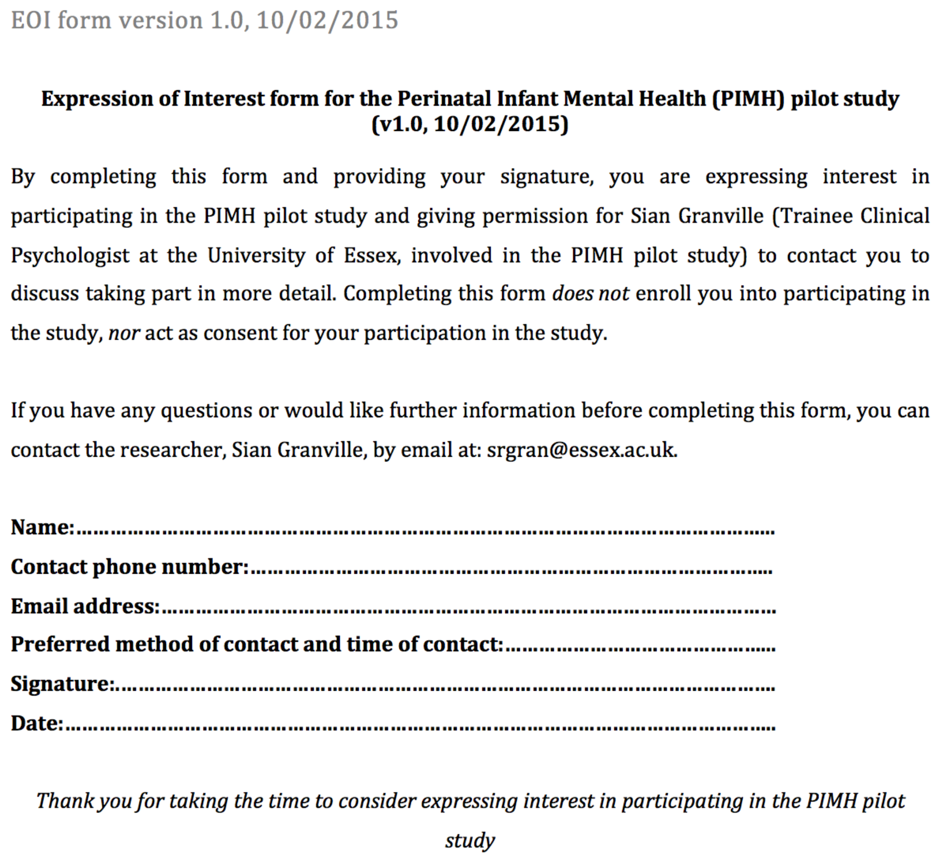
# Appendix A

Expression of Interest forms (EOIs) for clinician participants



EOI form version 1.0, 10/02/2015

**Expression of Interest form for the Perinatal Infant Mental Health (PIMH) pilot study (v1.0, 10/02/2015)**

By completing this form and providing your signature, you are expressing interest in participating in the PIMH pilot study and giving permission for Sian Granville (Trainee Clinical Psychologist at the University of Essex, involved in the PIMH pilot study) to contact you to discuss taking part in more detail. Completing this form *does not* enroll you into participating in the study, *nor* act as consent for your participation in the study.

If you have any questions or would like further information before completing this form, you can contact the researcher, Sian Granville, by email at: srgran@essex.ac.uk.

**Name:**……………………………………………………………………………………………………
**Contact phone number:**……………………………………………………………………………
**Email address:**………………………………………………………………………………………
**Preferred method of contact and time of contact:**……………………………………
**Signature:**…………………………………………………………………………………………
**Date:**………………………………………………………………………………………………

*Thank you for taking the time to consider expressing interest in participating in the PIMH pilot study*

## Appendix B

Information sheet for clinician participants

# INFORMATION SHEET FOR CLINICIAN PARTICIPANTS

**YOU WILL BE GIVEN A COPY OF THIS INFORMATION SHEET**

## Title of Study

The Perinatal Infant Mental Health pilot study

## Invitation Paragraph

I would like to invite you to take part in the Perinatal Infant Mental Health (PIMH) pilot study. The pilot study is part of the activity of the PIMH team within Norfolk and Suffolk NHS Foundation Trust, and will also form part of my course assessment in the form of a thesis for my training in clinical psychology at the University of Essex. You should only participate in this study if you want to; choosing not to take part will not disadvantage you in any way. Before you decide whether you want to take part, it is important for you to understand why the study is being done and what your participation will involve. Please take time to read the following information carefully and discuss it with others if you would like. Ask a member of the PIMH team involved in the study if there is anything that is not clear or if you would like more information. Contact details of relevant people involved in the study are also provided at the end of this information sheet.

## What is the purpose of the pilot study?

The aim of the pilot study is to evaluate the impact of the service offered by the PIMH team in terms of outcomes for the parents and infants that it sees. More specifically, the study will compare measures of wellbeing, functioning and parent-infant patterns of relating before and after involvement with the PIMH service and explore how the ways the clinicians who work with the parents and infants talk about relating connects to the outcomes for the parents and infants. For the parents and infants, this will involve completing questionnaires and taking part in interviews and assessments as part of their routine involvement with the PIMH service. For the clinicians working with them, this will involve taking part in an interview with myself at completion of their work with the individual parents and infants. The aim is to use this information to contribute to changes and improvements to the service, and to assess the usefulness to clinical practice of exploring how the clinicians who work with the parents and infants talk and think about relating in understanding individual outcomes.

## Who is organising the pilot study?

The pilot study is being undertaken by the PIMH team of Norfolk and Suffolk NHS Foundation Trust led by Dr Catherine Thomas, and myself Sian Granville, based at the University of Essex.

## Why have I been invited to take part?

I am inviting clinicians who have worked closely with the parents and infants who are involved with the PIMH service to take part in an interview with myself, as I believe you can contribute important information that may be relevant to the study aims.

## Do I have to take part?

Participation is entirely voluntary. You do not have to take part. You should read this information sheet and if you have any questions you should ask myself or a member of the PIMH team involved in the pilot study. You should not agree to take part in this study until you have had all your questions answered satisfactorily.

## What will happen to me if I take part?

If you are interested in participating in the pilot study, you will be given this information sheet to keep, and will be asked to complete an ‘Expression of Interest form’ which includes providing your contact details and giving permission for me to contact you to discuss taking part. If you are happy to take part you will then be asked to sign a consent form. There are two parts to this pilot study; for clinicians, participation will involve completing a demographic questionnaire and an individual interview to hear about their thoughts and experiences of working and relating with the particular parents and infants seen by the PIMH service, as well as their experiences of relating professionally and personally more generally. For the parents involved with the PIMH service, the information they provide as part of their routine involvement with the PIMH service through questionnaires and assessments will be collated and analysed as part of the pilot study.

If you complete an ‘Expression of Interest’ form, I will contact you at a time that is convenient for you to discuss participating and the interview procedure. On request you will be given the interview topic guide which lays out the areas I would like to discuss with you. With your consent, I will arrange to interview you in a private area (for confidentiality reasons) at the PIMHS base at a convenient time for you.

If you are happy to take part, you will be asked to sign a consent form on the day of participating and given a copy of this to keep for your records. The demographic form can take approximately 5 minutes to complete and asks questions such as your age, gender identity, ethnicity and level of educational achievement. The interview will take approximately 45-60 minutes and is based on an interview topic guide but it is designed to be flexible so as to meet your needs. The interview will be audio recorded if you give permission and it can also be helpful for me to take some notes whilst we talk. Recordings of interviews will be deleted after transcription, which involves typing up the recordings.

Even if you decide to take part, you are still free to stop your participation at any time and to have the information/data relating to you withdrawn without giving any reason up to the point of submitting the report of the pilot study for assessment to the University of Essex Doctorate in Clinical Psychology course in Summer 2016.

## Incentives

There is no financial incentive to take part in this pilot study.

## What are the possible risks of taking part?

There are no foreseeable risks in participating in the pilot study. The main disadvantage to taking part in the study is that you will be donating around 60-75 minutes of your time to take part in the interview plus travel time. It is possible that you may find answering some of the questions challenging. This is unlikely but if it were to occur the interview could be stopped at any time.

Whilst you will be asked to answer questions regarding your experiences of working and relating with parents and infants, all information provided by you will kept confidential. All responses to the questions and information provided by you will be anonymised i.e. no personally identifying details relating to you will be recorded. Only members of the PIMH team directly involved in the pilot study will have access to the information you provide.

## What are the possible benefits of taking part?

There are no direct benefits to taking part. However, the contribution you provide and the information we get from the pilot study will help to influence and improve the service offered by the PIMH service to parents, infants and families. Furthermore, I will also provide you with a summary of the final report describing the main findings and themes, including any implications for clinical practice.

## Will my taking part be kept confidential?

If you agree to take part you will be assigned an identification number. This will be used instead of your name on the study documents and materials such as the demographic form and recordings and transcriptions of the interviews. This is to protect your identity and ensure that the information and data we collect is anonymous. The answers given on the demographic forms and what is said in the interviews is regarded as strictly confidential and will be held securely until the study is finished after which it will be destroyed. Your participation is entirely voluntary. If you change your mind, you are free to stop your participation and to have your data withdrawn without giving any reason up to the point of submitting the report of the study for my course assessment in Summer 2016. All data for analysis will be anonymised. In reporting and disseminating on the study findings, I will not reveal any identifiable details of participants. In reporting the findings from the interviews it is good practice to use verbatim quotes to directly illustrate what people have said. These quotes will be anonymous, however it is possible you may recognise your own words. I must however inform you that if you disclose anything that we feel is a serious risk to your or other people's safety and well-being, we will need to share that with the appropriate professionals. If this situation arises I will discuss all possible options for ourselves and you before deciding whether or not to take any action.

The UK Data Protection Act 1998 will apply to all information gathered for the study and held on password-locked computer files and in locked cabinets. No data will be accessed by anyone other than the PIMH team involved in the pilot study and myself; and anonymity of the material will be protected by using identification numbers instead of names. You may withdraw your data from the project anytime up to the point of submitting the pilot study in the form of a thesis for my course assessment in Summer 2016. All recordings of data on audio-equipment will be deleted after transcription. If you ask me to withdraw your data at any time before Summer 2016 I will remove all traces of it from the records.

## What will happen to the results of the study?

All information provided by you will be stored anonymously on a password-protected computer, with analysis of the information obtained undertaken by myself, based at the University of Essex. I will produce a summary of the main findings of the study, which will be sent to you. The results of the pilot study will be submitted in the form of a thesis to my course tutors as a partial requirement of the Doctorate in Clinical Psychology run by the University of Essex and Tavistock Centre. The results will also be disseminated to the PIMH team and may be submitted for publication in a peer reviewed academic journal.

## Who should I contact for further information?

If you have any questions or require more information about this study, please contact myself or Dr Catherine Thomas, using the following contact details:

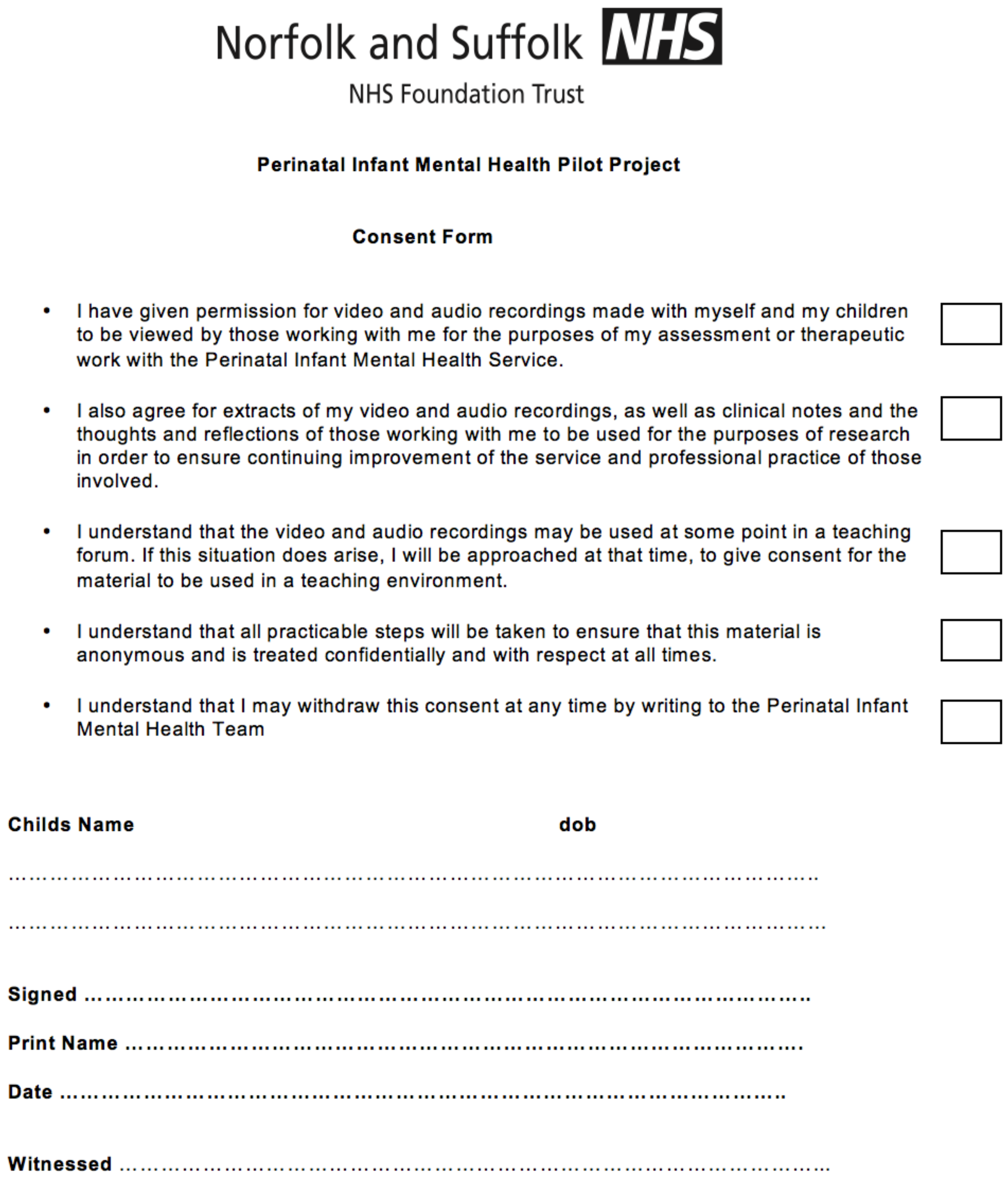
Sian Granville (Trainee Clinical Psychologist): srgran@essex.ac.uk

Dr Catherine Thomas (Consultant Child and Adolescent Psychiatrist): Catherine.thomas@nsft.nhs.uk.

**Thank you for reading this information sheet and for considering taking part in this study.**

# Appendix C

Parent consent form devised by the PIMHS



Norfolk and Suffolk NHS
NHS Foundation Trust

**Perinatal Infant Mental Health Pilot Project**

**Consent Form**

- I have given permission for video and audio recordings made with myself and my children to be viewed by those working with me for the purposes of my assessment or therapeutic work with the Perinatal Infant Mental Health Service. ☐
- I also agree for extracts of my video and audio recordings, as well as clinical notes and the thoughts and reflections of those working with me to be used for the purposes of research in order to ensure continuing improvement of the service and professional practice of those involved. ☐
- I understand that the video and audio recordings may be used at some point in a teaching forum. If this situation does arise, I will be approached at that time, to give consent for the material to be used in a teaching environment. ☐
- I understand that all practicable steps will be taken to ensure that this material is anonymous and is treated confidentially and with respect at all times. ☐
- I understand that I may withdraw this consent at any time by writing to the Perinatal Infant Mental Health Team ☐

**Childs Name** **dob**

……………………………………………………………………………………………

……………………………………………………………………………………………

**Signed** ……………………………………………………………………………………

**Print Name** ………………………………………………………………………………

**Date** ………………………………………………………………………………………

**Witnessed** ………………………………………………………………………………

# Appendix D

Interview schedule

In this interview I will ask you to recount situations in which you have had certain experiences with the parents and children you have worked with as part of the PIMHS project, as well as your thoughts about yourself as a clinician and your experience of this work more generally.

With your permission, I will use an audio recorder to tape our conversation to help make sure that I use what you say accurately. I would also like to take some brief notes about our conversation- for example how long we spoke for, where we spoke and how we spoke together. If you are happy and consent to, it would be helpful to have you write some brief notes about your experience of the interview too including the things I just mentioned and how you found the process. These notes will help me think about how our experience today might influence what we say and helps to clarify the process of collecting the information for this study.

A. **View and description**
    - Of their work context
    - Of themselves as a clinician
    - Of the children they work with
    - Of the parents they work with
    - Of the parent-child relationships

B. **View of the clinician's relationships with the parent-child dyad**s
    - Words/phrases to reflect their relationships, with specific examples to illustrate
    - Times when they 'clicked' and didn't 'click'
    - Reflections on how their relationships affected the dyads over the course of their time together

C. **Affective experience**
    - Of being a clinician
    - Of being a clinician engaged in work with these particular parents and children

D. **Clinician's history**
    - Reflections on their professional history (when first considered this work, how professional journey influences their work with parents and infants)

E. **Team working and professional relationships**
    - Reflections on relationship with others involved in work with the parents and infants care (times when have felt 'in sync' and times when haven't seen 'eye to eye', influence upon the work)

- Experience of support for the clinician in their work with the parents and infants

**F. Separation/Loss**

- Reflections on experiences and impact of separations, breaks and ruptures in relationships, and endings
- In their professional work in general
- In working with the particular parents and infants

**G. Change/no change**

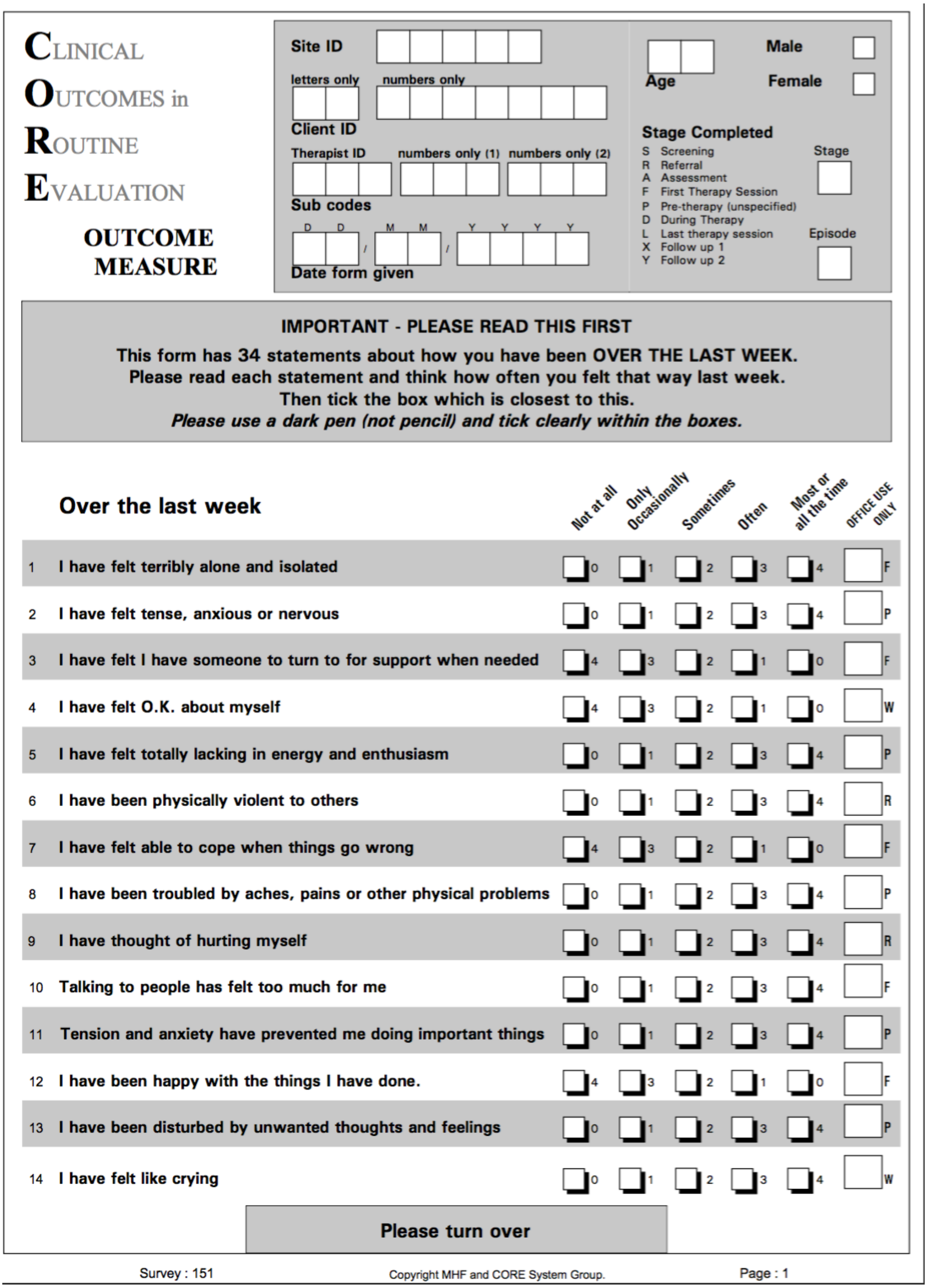
- Reflections on situations with the parents and infants where changes happened that they felt glad about (what contributed)
- Reflections on situations with the parents and infants where things didn't change or got worse (what contributed)

**H. Integrative questions**

- Reflections on what they would and wouldn't change if they had the time over with the parents and infants
- Opportunity to add anything else that would help to understand them as a clinician or their relationships with the parents and infants/processes of their work

# Appendix E

The Clinical Outcomes for Routine Evaluation – Outcome Measure (CORE-OM)



**CLINICAL OUTCOMES in ROUTINE EVALUATION**

**OUTCOME MEASURE**

**Site ID** ☐☐☐☐☐

letters only ☐☐ numbers only ☐☐☐☐☐☐☐

**Client ID**

Therapist ID ☐☐☐ numbers only (1) ☐☐☐ numbers only (2) ☐☐☐

**Sub codes**

D D / M M / Y Y Y Y

☐☐ / ☐☐ / ☐☐☐☐

**Date form given**

☐☐ **Age**

**Male** ☐

**Female** ☐

**Stage Completed**

S Screening
R Referral
A Assessment
F First Therapy Session
P Pre-therapy (unspecified)
D During Therapy
L Last therapy session
X Follow up 1
Y Follow up 2

Stage ☐

Episode ☐

**IMPORTANT - PLEASE READ THIS FIRST**

**This form has 34 statements about how you have been OVER THE LAST WEEK.**
**Please read each statement and think how often you felt that way last week.**
**Then tick the box which is closest to this.**
***Please use a dark pen (not pencil) and tick clearly within the boxes.***

| | **Over the last week** | Not at all | Only Occasionally | Sometimes | Often | Most or all the time | OFFICE USE ONLY |
|---|---|---|---|---|---|---|---|
| 1 | **I have felt terribly alone and isolated** | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 | ☐ F |
| 2 | **I have felt tense, anxious or nervous** | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 | ☐ P |
| 3 | **I have felt I have someone to turn to for support when needed** | ☐ 4 | ☐ 3 | ☐ 2 | ☐ 1 | ☐ 0 | ☐ F |
| 4 | **I have felt O.K. about myself** | ☐ 4 | ☐ 3 | ☐ 2 | ☐ 1 | ☐ 0 | ☐ W |
| 5 | **I have felt totally lacking in energy and enthusiasm** | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 | ☐ P |
| 6 | **I have been physically violent to others** | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 | ☐ R |
| 7 | **I have felt able to cope when things go wrong** | ☐ 4 | ☐ 3 | ☐ 2 | ☐ 1 | ☐ 0 | ☐ F |
| 8 | **I have been troubled by aches, pains or other physical problems** | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 | ☐ P |
| 9 | **I have thought of hurting myself** | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 | ☐ R |
| 10 | **Talking to people has felt too much for me** | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 | ☐ F |
| 11 | **Tension and anxiety have prevented me doing important things** | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 | ☐ P |
| 12 | **I have been happy with the things I have done.** | ☐ 4 | ☐ 3 | ☐ 2 | ☐ 1 | ☐ 0 | ☐ F |
| 13 | **I have been disturbed by unwanted thoughts and feelings** | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 | ☐ P |
| 14 | **I have felt like crying** | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 | ☐ W |

**Please turn over**

Survey : 151

Page : 1

## Over the last week

| | | Not at all | Only Occasionally | Sometimes | Often | Most or all the time | OFFICE USE ONLY |
|---|---|---|---|---|---|---|---|
| 15 | I have felt panic or terror | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 | ☐ P |
| 16 | I made plans to end my life | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 | ☐ R |
| 17 | I have felt overwhelmed by my problems | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 | ☐ W |
| 18 | I have had difficulty getting to sleep or staying asleep | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 | ☐ P |
| 19 | I have felt warmth or affection for someone | ☐ 4 | ☐ 3 | ☐ 2 | ☐ 1 | ☐ 0 | ☐ F |
| 20 | My problems have been impossible to put to one side | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 | ☐ P |
| 21 | I have been able to do most things I needed to | ☐ 4 | ☐ 3 | ☐ 2 | ☐ 1 | ☐ 0 | ☐ F |
| 22 | I have threatened or intimidated another person | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 | ☐ R |
| 23 | I have felt despairing or hopeless | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 | ☐ P |
| 24 | I have thought it would be better if I were dead | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 | ☐ R |
| 25 | I have felt criticised by other people | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 | ☐ F |
| 26 | I have thought I have no friends | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 | ☐ F |
| 27 | I have felt unhappy | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 | ☐ P |
| 28 | Unwanted images or memories have been distressing me | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 | ☐ P |
| 29 | I have been irritable when with other people | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 | ☐ F |
| 30 | I have thought I am to blame for my problems and difficulties | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 | ☐ P |
| 31 | I have felt optimistic about my future | ☐ 4 | ☐ 3 | ☐ 2 | ☐ 1 | ☐ 0 | ☐ W |
| 32 | I have achieved the things I wanted to | ☐ 4 | ☐ 3 | ☐ 2 | ☐ 1 | ☐ 0 | ☐ F |
| 33 | I have felt humiliated or shamed by other people | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 | ☐ F |
| 34 | I have hurt myself physically or taken dangerous risks with my health | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 | ☐ R |

**THANK YOU FOR YOUR TIME IN COMPLETING THIS QUESTIONNAIRE**

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Total Scores** | ☐ ↓ | ☐ ↓ | ☐ ↓ | ☐ ↓ | → | ☐ ↓ | → | ☐ ↓ |
| **Mean Scores**<br>(Total score for each dimension divided by number of items completed in that dimension) | ☐ | ☐ | ☐ | ☐ | | ☐ | | ☐ |
| | (W) | (P) | (F) | (R) | | All items | | All minus R |

# Appendix F

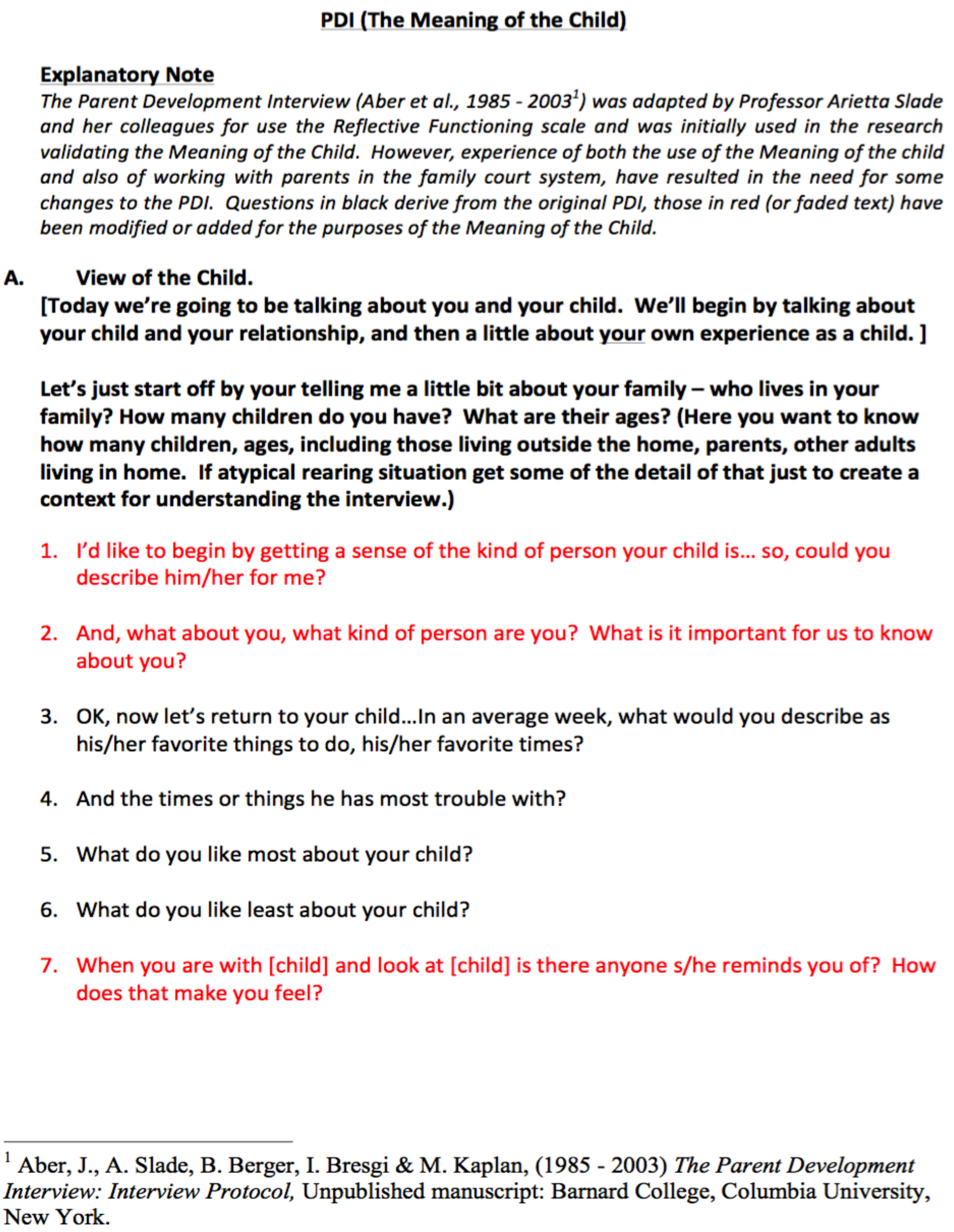
The Mother Object Relationship Scale – Short Form (MORS-SF)

**Statements** (Please tick the appropriate box)

| | **Always** | **Very Often** | **Quite Often** | **Sometimes** | **Rarely** | **Never** |
|---|---|---|---|---|---|---|
| My baby smiles at me | | | | | | |
| My baby annoys me | | | | | | |
| My baby likes doing things with me | | | | | | |
| My baby ‘talks’ to me | | | | | | |
| My baby irritates me | | | | | | |
| My baby likes me | | | | | | |
| My baby wants too much attention | | | | | | |
| My baby laughs | | | | | | |
| My baby gets moody | | | | | | |
| My baby dominates me | | | | | | |
| My baby likes to please me | | | | | | |
| My baby cries for no obvious reason | | | | | | |
| My baby is affectionate towards me | | | | | | |
| My baby winds me up | | | | | | |

# Appendix G

The protocol of the Parent Development Interview (PDI) adapted for the Meaning of the Child Interview (MotC) and the MotC coding sheet. The former represents the interview schedule that was completed with parents as part of their routine service engagement with the PIMHS. The latter is the coding sheet that was completed by blind raters for the purposes of establishing a dominant pattern and level of risk within the parent-infant relaitonships according to MotC criteria.



## PDI (The Meaning of the Child)

**Explanatory Note**
*The Parent Development Interview (Aber et al., 1985 - 2003[1]) was adapted by Professor Arietta Slade and her colleagues for use the Reflective Functioning scale and was initially used in the research validating the Meaning of the Child. However, experience of both the use of the Meaning of the child and also of working with parents in the family court system, have resulted in the need for some changes to the PDI. Questions in black derive from the original PDI, those in red (or faded text) have been modified or added for the purposes of the Meaning of the Child.*

**A. View of the Child.**
**[Today we're going to be talking about you and your child. We'll begin by talking about your child and your relationship, and then a little about your own experience as a child. ]**

**Let's just start off by your telling me a little bit about your family – who lives in your family? How many children do you have? What are their ages? (Here you want to know how many children, ages, including those living outside the home, parents, other adults living in home. If atypical rearing situation get some of the detail of that just to create a context for understanding the interview.)**

1. I'd like to begin by getting a sense of the kind of person your child is… so, could you describe him/her for me?

2. And, what about you, what kind of person are you? What is it important for us to know about you?

3. OK, now let's return to your child…In an average week, what would you describe as his/her favorite things to do, his/her favorite times?

4. And the times or things he has most trouble with?

5. What do you like most about your child?

6. What do you like least about your child?

7. When you are with [child] and look at [child] is there anyone s/he reminds you of? How does that make you feel?

---

[1] Aber, J., A. Slade, B. Berger, I. Bresgi & M. Kaplan, (1985 - 2003) *The Parent Development Interview: Interview Protocol,* Unpublished manuscript: Barnard College, Columbia University, New York.

## B. View of the Relationship

1. I'd like you to choose 3 words or phrases that you feel reflect the relationship between you and (your child). (Pause while they list adjectives.) Now let's go back over each of the words or phrases you choose. Does an incident or memory come to mind with respect to _____? (Go through and get a specific memory for each adjective.)

2. Describe a time in the last week when you and (your child) really "clicked". (Probe if necessary: Can you tell me more about the incident? How did you feel? How do you think (your child) felt?)

3. Now, describe a time in the last week when you and (your child) really weren't "clicking". (Probe if necessary: Can you tell me more about the incident? How did you feel? How do you think (your child) felt?)

4. How do you think your relationship with your child is affecting his/her development or personality?

## C. Affective Experience of Parenting

1. Now, we're going to talk about your feelings about being a parent. How would you describe yourself as a parent? [If necessary probe: Can you give me an example of this?]

2. What gives you the most joy in being a parent?

3. What gives you the most pain or difficulty in being a parent?

4. When you worry about (your child), what do you find yourself worrying most about?

5. How has having your child changed you?

6. Tell me about a time in the last week or two when you felt really angry as a parent. (Probe, if necessary: Can you tell me a little bit more about the situation? How did you handle your angry feelings?)

6a. What kind of effect do these feelings have on your child?

7. Tell me about a time recently when you felt really guilty as a parent. (Probe, if necessary: Can you tell me a little bit more about the situation? How did you handle your guilty feelings?)

7a. What kind of effect do these feelings have on your child?

8. Tell me about a time in the last week or two when you felt you really needed someone to take care of *you*. (Probe, if necessary: Can you tell me a little bit more about the situation? How did you handle your needy feelings?)

8a. What kind of effect do these feelings have on (your child?)

9. When your child is upset, what does he/she do? Can you tell me about a recent time when s/he was upset? How does that make you feel? What do you do?

10. Does (your child) ever feel rejected?

**D. Parent's Family History:**

**[Where a full AAI has already been given, skip questions 1 - 3]**

Now I'd like to ask you a few questions about your own parents, and about how your childhood experiences might have affected your feelings about parenting….

1. Could you just tell me something about your childhood family; who you grew up with, what your childhood relationship with your parents was like, that kind of thing?
2. I'd like you to choose 3 words or phrases that describe your childhood relationship with your mother, from as early as you can remember….Now let's go back over each adjective. Does an incident or memory come to mind with respect to?
3. Now can you choose 3 words or phrases that describe your childhood relationship with your father? (Pause while they list adjectives.) Now let's go back over each adjective. Does an incident or memory come to mind with respect to _____?
4. How do you want to be like and unlike your mother as a parent?
5. How about your father?
6. Do you think there are any ways in which you ***are*** like your mother? .. father?

**E. Co-Parenting and Family Relationships**

I would just like to ask a few questions about C.'s father/mother and other relationships within your family:

1. Can you tell me a bit about C's father/mother [other parent]? What kind of parent is s/he? [**Probe if necessary**: what is her/his involvement in C.s life? Where things any different when C. was born? How do you feel about this?]

2. How does C. feel about her/his [birth] father/mother? **(Probe**: How do you feel about this?)

3. A *[If living with a partner who is* ***not*** *the child's father/mother]* What about [partner], how does C. get on with him/her? *[If relevant:* How did C. feel about you coming together?] How does s/he feel about C.? What is his/her relationship with C.'s father/mother like?

   **Or** *[if either single or living with the child's other parent]*:
   B How does [other parent] get on with c.? Tell me about a time s/he spent with C. and how it went? (Probe: How does this make you feel?)

4. Can you tell me about a time when you and [*select child's other parent or current partner, as relevant, or ask about both if pertinent*] haven't seen eye to eye about parenting C.? (Probe if necessary: How did that make you feel? How did this affect C.?)

5. What is C.'s relationship like with his/her brothers and sisters? Why do you think this is? How do you feel about this?

6. Who else is supportive to you in caring for C.? How does s/he get on with C.? Can you tell me about a time they spent together, and how it went?

### F. Separation/Loss

1. Now, I'd like you to think of a time you and your child weren't together, when you were separated. Can you describe it to me? ***(Probe: What kind of effect did it have on the child? What kind of effect did it have on you?)*** **NOTE:** Probe for a *recent* separation [within the last year].

2. Is there anyone very important to you who (your child) doesn't know but who you wish he/she was close to, or could have been close to if things had turned out differently?

3. Do you think there are experiences in your child's life that you feel have been a setback for him?

### G. Integrative Questions

1. Your child is _____ already, and you're an experienced parent. If you had the experience to do all over again, what would you change? What wouldn't you change?

2. We have spent some time looking at what it is like to be a parent, your experiences of being parented, and your relationship with [child]. Is there anything you would like to add that will help us understand you now as a parent, or feel we should know about your relationship with [child]?

**Parent/Family Name:** **Age of child:**

**Interview Date:**

## MEANING OF THE CHILD: CODING SHEET VERSION 2.2

### PROCEDURAL MEMORY

**Relationship with the Interviewer**

**Sensitive**: Open, Exploratory, Cooperative

**Controlling**: Seeking Ally, Hostile*, Self Justifying [Self-Glorifying*], Helpless, Paranoid/Suspicious*

**Unresponsive**: Unconnected, Compliant, Defers to Inv.*, Spectator*, Depressed*

**Expressed Affect:**

**Sensitive**: Moderate and appropriate, Pleasure, Affectionate humour, Sincere Affection

**Controlling**: Exaggerated Affect, Unresolved Anger/Fear(*), Mocking, Sighs (when talking about child), Sarcasm, Pleasure in Pain*

**Unresponsive**: Flat Affect, Suppressed Anxiety, Sad

### IMAGED MEMORY

**Sensitive**: Personal and 'Fresh', Balanced, Warm, Animated Affectionate Images

**Controlling**: Intense, Trivialising/Belittling, Hostile, Exaggerated / Delusional* Images of Anger/Fear/Danger/Comfort/Loss

**Unresponsive**: No images, Objectifying Images, Bizarre/Imagined (fantasised)*, Images of loss/hopelessness

### CONNOTATIVE LANGUAGE

**Sensitive**: Lively and Appropriate, Moderate

**Controlling**:, Evocative (negative), Evocative (positive), Violent, Dismissive, Trite, Derogatory/Profane*

**Unresponsive**: Absence of Needed Affect (ANA), Clichéd or Rote, Artificial & Technical, Eulogising language*

### SEMANTIC MEMORY

**Sensitive**: Nuanced, Balanced, Child Specific Understanding

**Controlling**: Child Blaming, Undermined Positive, Derogating*, Self-Exonerating [of harm*], Self-Serving (Grandiose*), Enmeshed (Projection*), Needs child, Triangulated blame or need*

**Unresponsive**: Idealising, Abdicating PR (Helpless)*, Role-Reversing*., Borrowed(*), Stereotyped, Concrete and Physical

### EPISODIC MEMORY

**Sensitive**: Balanced, Rich and Personal, Child in Mind, Appropriate Mentalising

**Controlling**: Undermining, Child in Control (Persecution*), Cloying (Sexualised*), One-Sided Episodes, Triangulated*, Self-Exalting*, Distorted Mentalising*, Refused Mentalising*

**Unresponsive**: Absent (LPE), Passive/Role-Reversing(*), Scripted, No Mentalising*, Fantasised Mentalising*

### REFLECTIVE INTEGRATION

**Sensitive**: Fresh thinking 'in action', Historical Insights, Awareness of Problems, Searching

**Controlling** Refused, Evade Responsibility(*), Dramatised Guilt*, Magic Future

**Unresponsive**: Stereotyped/Borrowed*, Distanced Int., Escapist Fantasy*, Futile*

**Unresponsive &/or Controlling:** Absent, Reversal Strategy, Oscillating*, Unintegrated Fragments

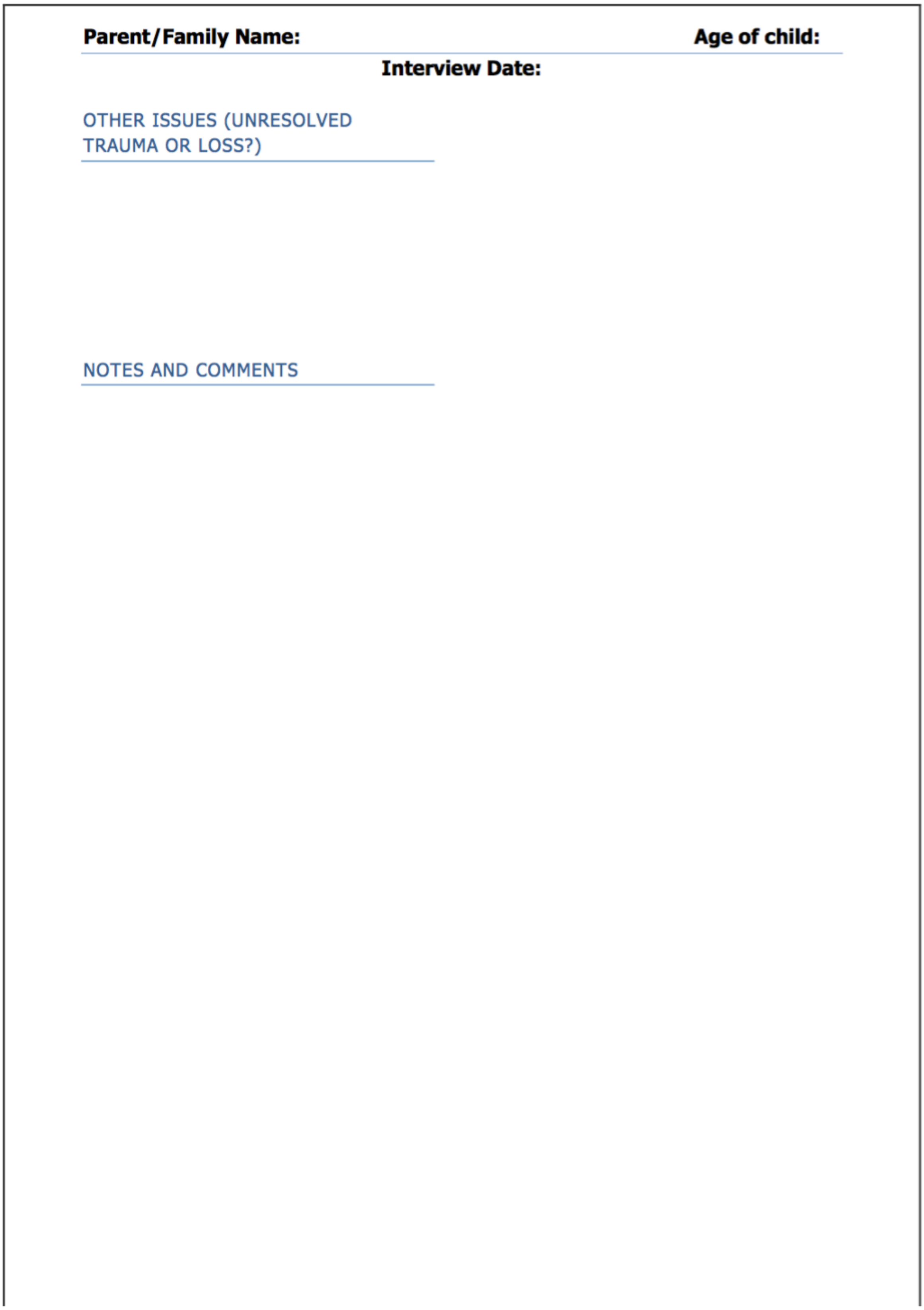
### OVERALL CLASSIFICATION

**Sensitivity / Risk:**

**Pattern:**

---

*Indicates High Risk



**Parent/Family Name:** **Age of child:**

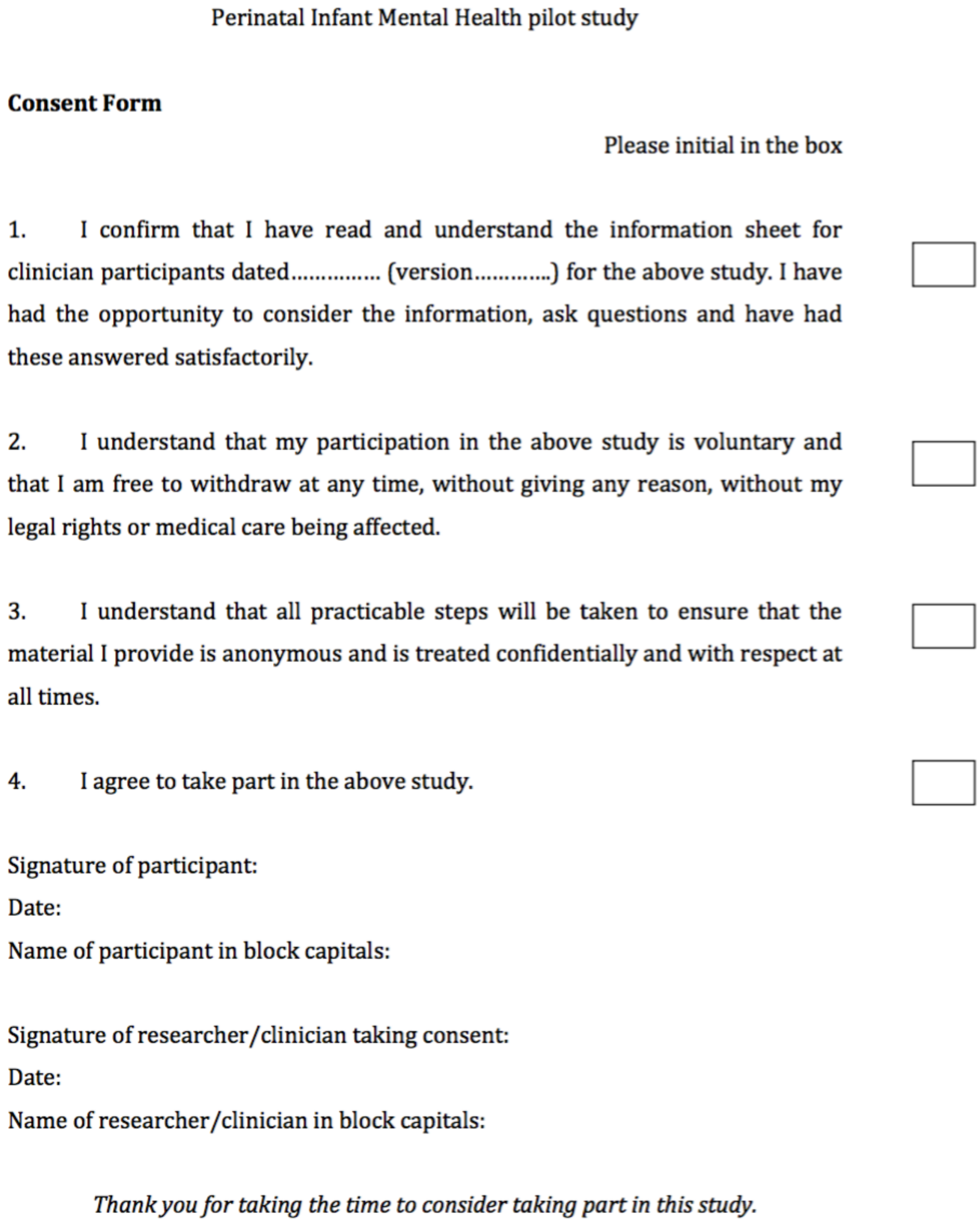
**Interview Date:**

OTHER ISSUES (UNRESOLVED TRAUMA OR LOSS?)

NOTES AND COMMENTS

# Appendix H

Clinician participant consent form



Perinatal Infant Mental Health pilot study

**Consent Form**

Please initial in the box

1. I confirm that I have read and understand the information sheet for clinician participants 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 in the above study is voluntary and that I am free to withdraw at any time, without giving any reason, without my legal rights or medical care being affected. ☐

3. I understand that all practicable steps will be taken to ensure that the material I provide is anonymous and is treated confidentially and with respect at all times. ☐

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

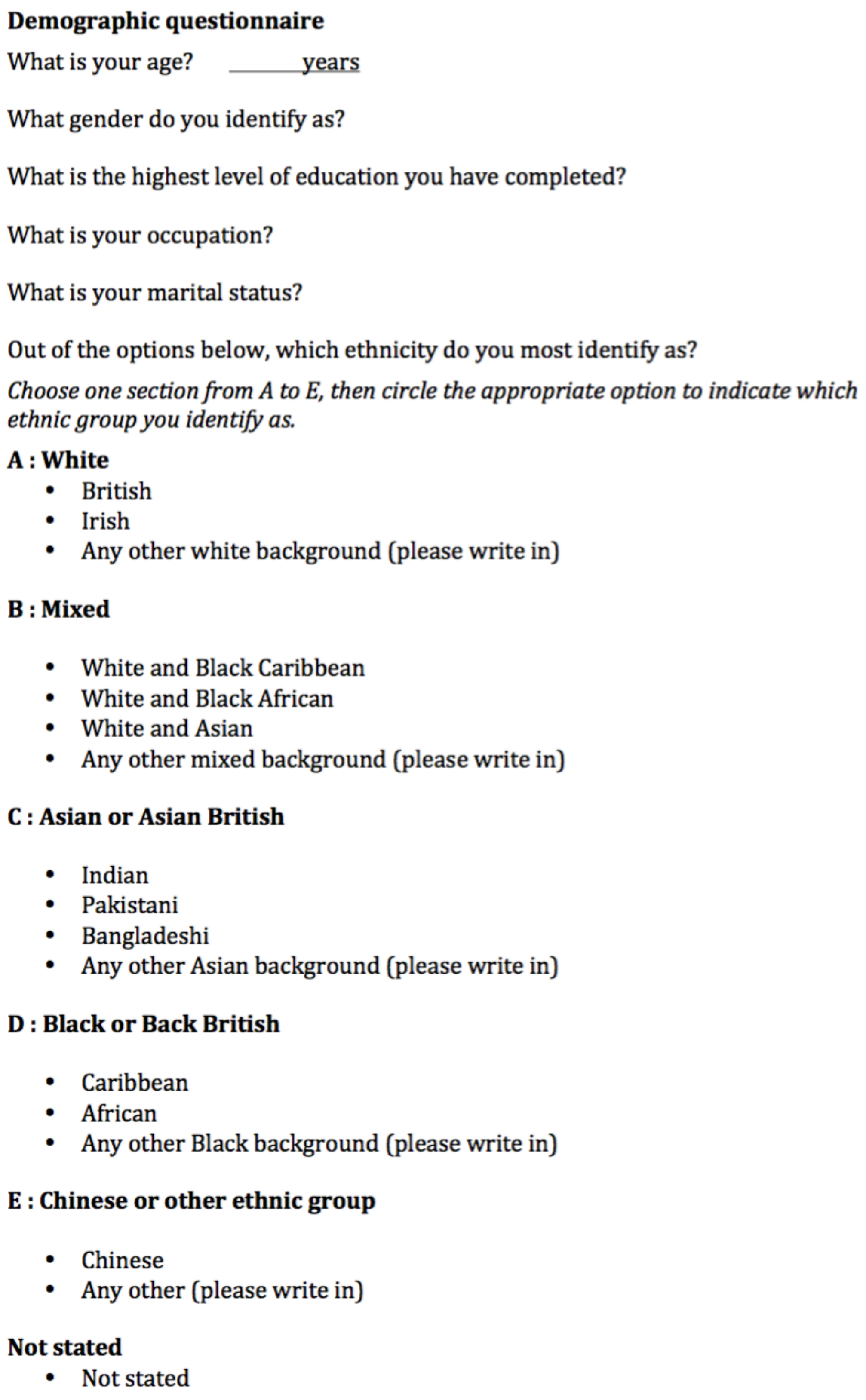
Signature of participant:
Date:
Name of participant in block capitals:

Signature of researcher/clinician taking consent:
Date:
Name of researcher/clinician in block capitals:

*Thank you for taking the time to consider taking part in this study.*

# Appendix I

Clinician participant demographic questionnaire



## Demographic questionnaire

What is your age? ________years

What gender do you identify as?

What is the highest level of education you have completed?

What is your occupation?

What is your marital status?

Out of the options below, which ethnicity do you most identify as?

*Choose one section from A to E, then circle the appropriate option to indicate which ethnic group you identify as.*

**A : White**

- British
- Irish
- Any other white background (please write in)

**B : Mixed**

- White and Black Caribbean
- White and Black African
- White and Asian
- Any other mixed background (please write in)

**C : Asian or Asian British**

- Indian
- Pakistani
- Bangladeshi
- Any other Asian background (please write in)

**D : Black or Back British**

- Caribbean
- African
- Any other Black background (please write in)

**E : Chinese or other ethnic group**

- Chinese
- Any other (please write in)

**Not stated**

- Not stated

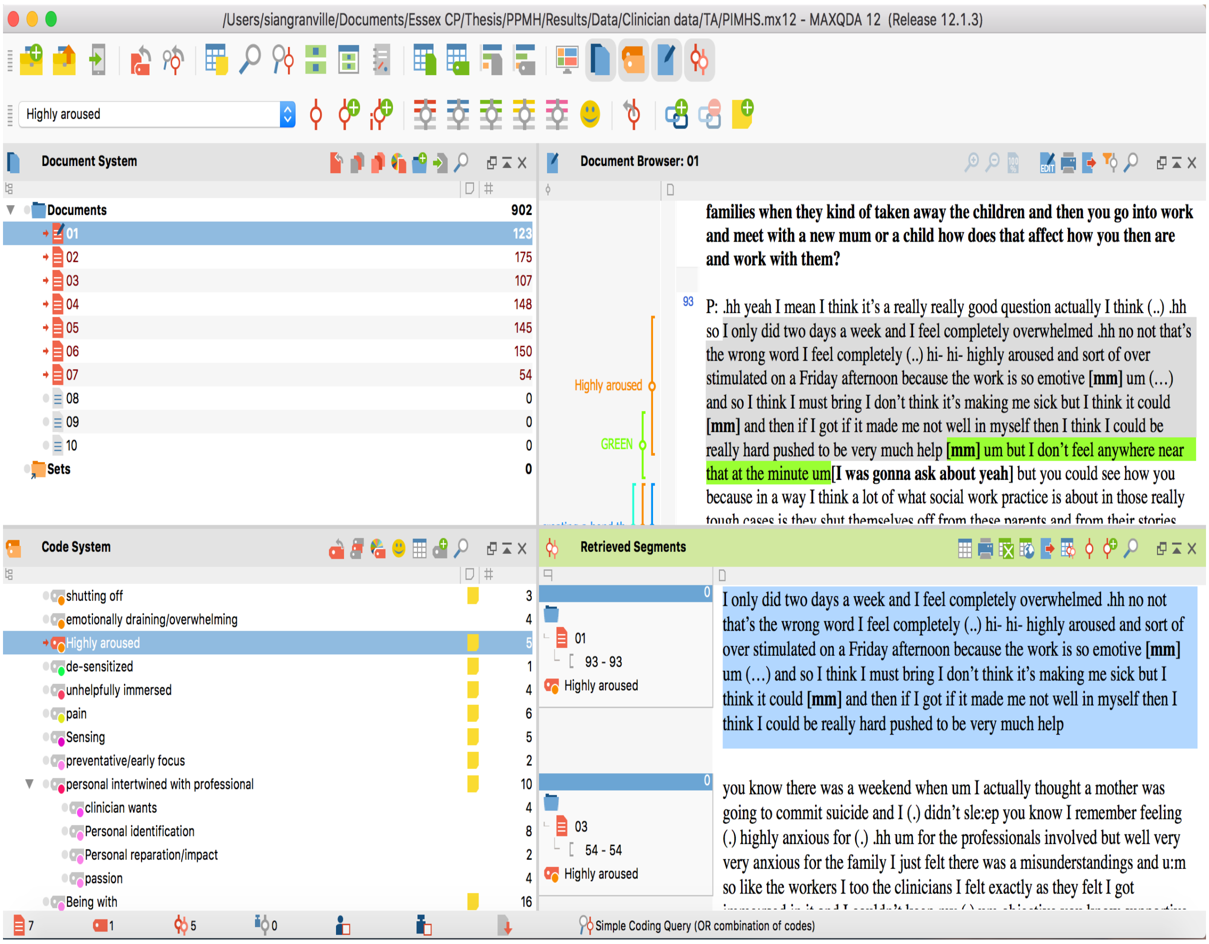
# Appendix J

Illustrations of the coding framework development and processes of thematic analysis.

Thematic analysis followed the six phases of analysis laid out by Braun and Clarke (2006) and the process was supported by MaxQDA. The six phases encompassed:

1. Familiarisation with the data set: interviews were transcribed and subject to ‘repeated reading’ to become familiar with the depth and breadth of the content.
2. Generation of initial codes: codes were identified as interesting features of the data and generated across the entire data set.
3. Searching for themes: once the entire data set was coded and extracts collated, codes were arranged into potential themes and memo notes supported the processes of thinking and decision making regarding the relationships between codes, themes and levels of themes.
4. Reviewing themes: themes were reviewed to consider their coherence and distinction from one another using candidate thematic maps. Themes were reviewed by referring to the collated coded data extracts as well as the data set as a whole.
5. Defining and naming themes: in this phase the ‘essence’ of what each theme represented was considered and accompanying narratives were developed. This phase was supported by thesis supervision to aid reliability.
6. Producing the report: writing the report entailed the final phase of the analysis through which the narrative of the data was supported by evidence in the form of quotes to illustrate themes and sub-themes.

The illustration below depicts extracts of the code ‘highly aroused’ during the middle stages of coding.



| Document System | # |
|---|---|
| Documents | 902 |
| 01 | 123 |
| 02 | 175 |
| 03 | 107 |
| 04 | 148 |
| 05 | 145 |
| 06 | 150 |
| 07 | 54 |
| 08 | 0 |
| 09 | 0 |
| 10 | 0 |
| Sets | 0 |

**families when they kind of taken away the children and then you go into work and meet with a new mum or a child how does that affect how you then are and work with them?**

93 P: .hh yeah I mean I think it’s a really really good question actually I think (..) .hh so I only did two days a week and I feel completely overwhelmed .hh no not that’s the wrong word I feel completely (..) hi- hi- highly aroused and sort of over stimulated on a Friday afternoon because the work is so emotive **[mm]** um (…) and so I think I must bring I don’t think it’s making me sick but I think it could **[mm]** and then if I got if it made me not well in myself then I think I could be really hard pushed to be very much help **[mm]** um but I don’t feel anywhere near that at the minute um**[I was gonna ask about yeah]** but you could see how you because in a way I think a lot of what social work practice is about in those really tough cases is they shut themselves off from these parents and from their stories

| Code System | # |
|---|---|
| shutting off | 3 |
| emotionally draining/overwhelming | 4 |
| Highly aroused | 5 |
| de-sensitized | 1 |
| unhelpfully immersed | 4 |
| pain | 6 |
| Sensing | 5 |
| preventative/early focus | 2 |
| personal intertwined with professional | 10 |
| clinician wants | 4 |
| Personal identification | 8 |
| Personal reparation/impact | 2 |
| passion | 4 |
| Being with | 16 |

7 1 5 0

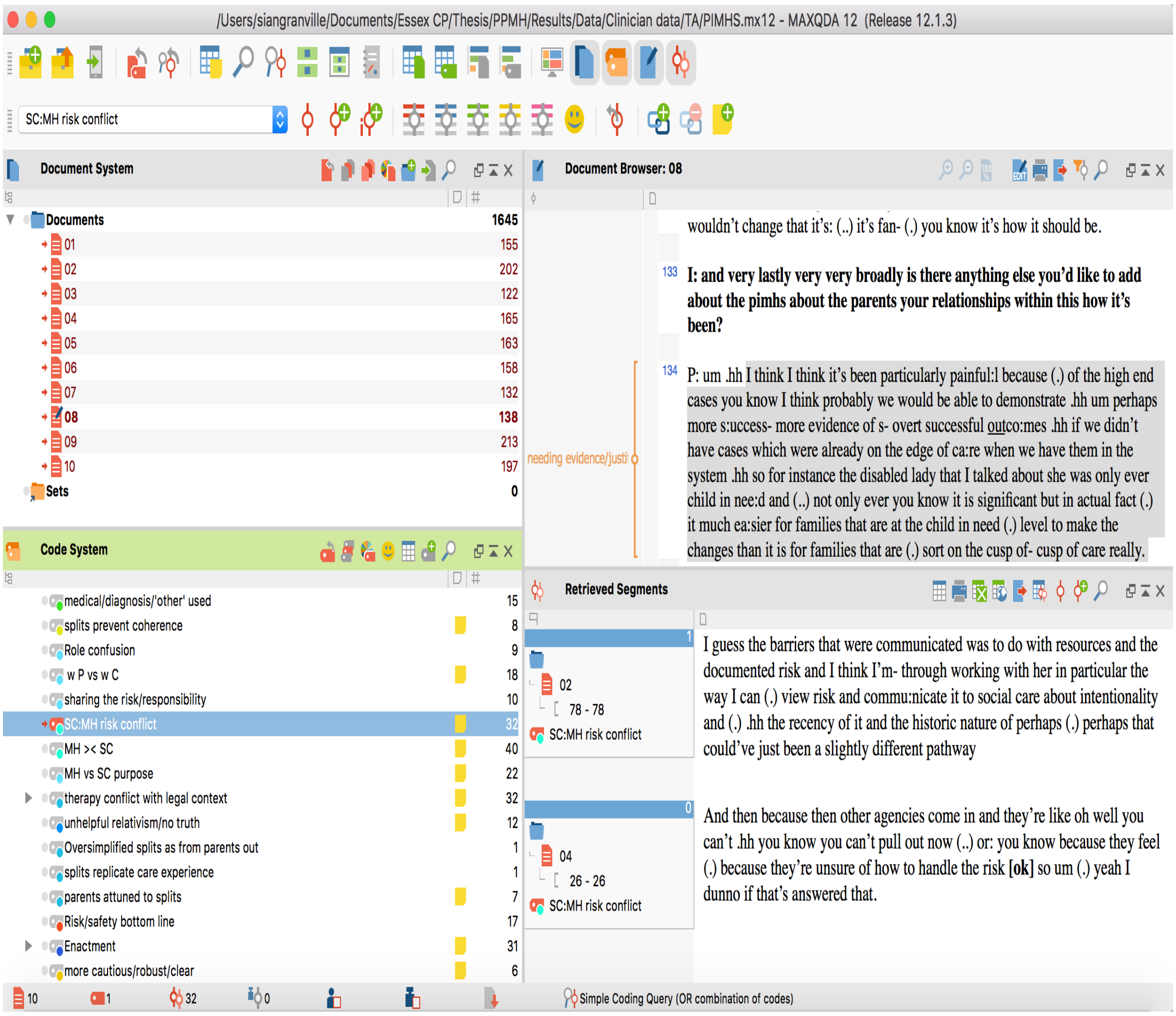
01
93 - 93
Highly aroused

I only did two days a week and I feel completely overwhelmed .hh no not that’s the wrong word I feel completely (..) hi- hi- highly aroused and sort of over stimulated on a Friday afternoon because the work is so emotive **[mm]** um (…) and so I think I must bring I don’t think it’s making me sick but I think it could **[mm]** and then if I got if it made me not well in myself then I think I could be really hard pushed to be very much help

03
54 - 54
Highly aroused

you know there was a weekend when um I actually thought a mother was going to commit suicide and I (.) didn’t sle:ep you know I remember feeling (.) highly anxious for (.) .hh um for the professionals involved but well very very anxious for the family I just felt there was a misunderstandings and u:m so like the workers I too the clinicians I felt exactly as they felt I got

The following illustration shows extracts for the code ‘social care: mental health risk conflict’ in the later stages of coding.



| Documents | 1645 |
|---|---|
| 01 | 155 |
| 02 | 202 |
| 03 | 122 |
| 04 | 165 |
| 05 | 163 |
| 06 | 158 |
| 07 | 132 |
| 08 | 138 |
| 09 | 213 |
| 10 | 197 |
| Sets | 0 |

| | |
|---|---|
| medical/diagnosis/'other' used | 15 |
| splits prevent coherence | 8 |
| Role confusion | 9 |
| w P vs w C | 18 |
| sharing the risk/responsibility | 10 |
| SC:MH risk conflict | 32 |
| MH >< SC | 40 |
| MH vs SC purpose | 22 |
| therapy conflict with legal context | 32 |
| unhelpful relativism/no truth | 12 |
| Oversimplified splits as from parents out | 1 |
| splits replicate care experience | 1 |
| parents attuned to splits | 7 |
| Risk/safety bottom line | 17 |
| Enactment | 31 |
| more cautious/robust/clear | 6 |

wouldn’t change that it’s: (..) it’s fan- (.) you know it’s how it should be.

133 **I: and very lastly very very broadly is there anything else you’d like to add about the pimhs about the parents your relationships within this how it’s been?**

134 P: um .hh I think I think it’s been particularly painful:l because (.) of the high end cases you know I think probably we would be able to demonstrate .hh um perhaps more s:uccess- more evidence of s- overt successful outco:mes .hh if we didn’t have cases which were already on the edge of ca:re when we have them in the system .hh so for instance the disabled lady that I talked about she was only ever child in nee:d and (..) not only ever you know it is significant but in actual fact (.) it much ea:sier for families that are at the child in need (.) level to make the changes than it is for families that are (.) sort on the cusp of- cusp of care really.

1
02
78 - 78
SC:MH risk conflict

I guess the barriers that were communicated was to do with resources and the documented risk and I think I’m- through working with her in particular the way I can (.) view risk and commu:nicate it to social care about intentionality and (.) .hh the recency of it and the historic nature of perhaps (.) perhaps that could’ve just been a slightly different pathway

0
04
26 - 26
SC:MH risk conflict

And then because then other agencies come in and they’re like oh well you can’t .hh you know you can’t pull out now (..) or: you know because they feel (.) because they’re unsure of how to handle the risk **[ok]** so um (.) yeah I dunno if that’s answered that.

The final coding framework is depicted below including the number of extracts that were attributed to each code. Related codes were grouped together for theme development.

| Code System | No. |
|---|---|
| Code System | 1645 |
| aligning with infant | 11 |
| infant maladapting | 9 |
| parent views MH exterior | 2 |
| complex/self-protective parental attachment | 2 |
| parental indifference | 2 |
| parent withholding/withdrawing | 20 |
| bringing in family | 5 |
| Connecting parent to other profs | 15 |
| admiration for parent | 3 |
| In future | 12 |
| aligning with parent | 9 |
| becoming/being a parent | 18 |
| drift/losing focus | 12 |
| Having tried | 6 |
| ordinary unhappiness/good enough | 13 |
| risk/threat to prof | 11 |
| normative discourse of motherhood | 5 |
| MH barrier to parenthood | 8 |
| infant objectified | 1 |
| threat of losing baby | 17 |
| creating a bond that gets broken | 8 |
| Creating safe base | 6 |
| experience/freedom to be flexible/manage | 4 |
| Boundaries | 12 |
| insensitivity/protocols | 3 |
| SC pressured | 13 |
| SC ultimate power/responsibility | 15 |
| SC depicted as unfeeling/threatening/blamed | 22 |
| Sc ostracized/outside | 9 |
| medical/diagnosis/'other' used | 15 |
| splits prevent coherence | 8 |
| Role confusion | 9 |
| w P vs w C | 18 |
| sharing the risk/responsibility | 10 |
| SC:MH risk conflict | 32 |
| MH >< SC | 40 |
| MH vs SC purpose | 22 |
| therapy conflict with legal context | 20 |

| | |
|---|---|
| legal context helpful | 1 |
| power/danger of naming/prof language | 11 |
| unhelpful relativism/no truth | 12 |
| Oversimplified splits as from parents out | 1 |
| splits replicate care experience | 1 |
| parents attuned to splits | 7 |
| Risk/safety bottom line | 17 |
| Enactment | 22 |
| Enactment w p | 9 |
| more cautious/robust/clear | 6 |
| Open | 28 |
| non-blaming | 13 |
| shutting off | 2 |
| de-sensitized | 2 |
| emotionally draining/overwhelming | 6 |
| Highly aroused | 24 |
| unhelpfully immersed | 6 |
| pain/sadness | 19 |
| Hope | 16 |
| Really caring for | 6 |
| proving yourself/inadequacy | 20 |
| Searching/lingering | 27 |
| preventative/early focus | 3 |
| personal intertwined with professional | 25 |
| clinician wants | 4 |
| Personal identification | 9 |
| Personal reparation/impact | 5 |
| passion | 13 |
| Being with | 30 |
| Being tentative | 3 |
| Sensing | 6 |
| Congruence | 5 |
| Witnessing love/connection | 14 |
| noticing moments of interaction | 11 |
| Infant as a way in | 7 |
| Connecting/trust through play | 8 |
| t-p parallels p-c | 4 |
| Professional holds | 9 |
| Professional as parent/model | 14 |
| Seeing | 11 |
| distance/closeness | 21 |
| parental insight/RF/potential | 12 |
| parental ownership/recognition | 34 |
| real/core sadness/pain | 5 |
| GREEN | 8 |

| | |
|---|---|
| MAGENTA | 2 |
| YELLOW | 5 |
| BLUE | 7 |
| mattering to parents? | 2 |
| Going beyond remit/role | 8 |
| more than techniques | 4 |
| pragmatic/responsive | 11 |
| commitment | 23 |
| repairing/ruptures | 9 |
| consistency | 20 |
| engagement | 15 |
| low currency of help/ambivalence | 8 |
| Working up | 2 |
| Ax guides | 8 |
| p c conflicting timescales | 4 |
| RF/relationship not enough alone | 11 |
| system precluding change | 14 |
| Incongruence | 2 |
| stopping history repeating | 29 |
| reciprocal prof respect/trust | 10 |
| repairing/preventing splits | 17 |
| complementary views/roles | 28 |
| creating space/time | 16 |
| having a space (prof) | 46 |
| Naming w p/c | 29 |
| forum/prof naming | 9 |
| Symbolizing | 34 |
| Research Literature Training | 43 |
| sharing/spreading the word | 13 |
| Instability/unpredictability | 8 |
| history repeating | 19 |
| Structural/systemic inhibiting backdrop | 21 |
| health/political context | 36 |
| limits of ax | 5 |
| limits of work | 19 |
| competing demands | 8 |
| living without services | 12 |
| therapy opposing dominant narratives | 21 |
| proving expectations wrong/overcoming | 18 |
| needing evidence/justification | 15 |
| isolation/marginalization | 19 |
| parents set up to fail | 2 |
| ending/cutting off | 14 |
| local historical context | 2 |
| Unnamed powers | 2 |

| | |
|---|---|
| Community setting | 7 |
| Less stigmatizing | 2 |
| Not medical model | 10 |
| view of interviewer | 11 |
| maternal projection | 1 |

## Appendix K

Ethical approval for the study from the host trust of PIMHS

Norfolk and Suffolk NHS
NHS Foundation Trust

**Research and Development**
**The Knowledge Centre**
Hellesdon Hospital
Drayton High Road
Norwich
NR6 5BE
**Telephone** 01603 42552
**E mail:** RDofficemailbox@nsft.nhs.uk

7th April 2015

Dr Catherine Thomas
Child and Adolescent Psychiatrist
Silverwood Centre
Northgate Hospital
Great Yarmouth
NR30 1BU

**Re: Evaluation of Lowestoft and Waveney Perinatal Infant Mental Health (PIMHS) Pilot Project**

Thank you for submitting the above project for Service Evaluation Registration. I am happy to confirm that the Evaluation has been reviewed and given permission to be undertaken in the following organisation:

- **Norfolk & Suffolk NHS Foundation Trust**

Please note that this authorisation is only valid for the specific submitted project, and does not include any future or additional projects in the same team.

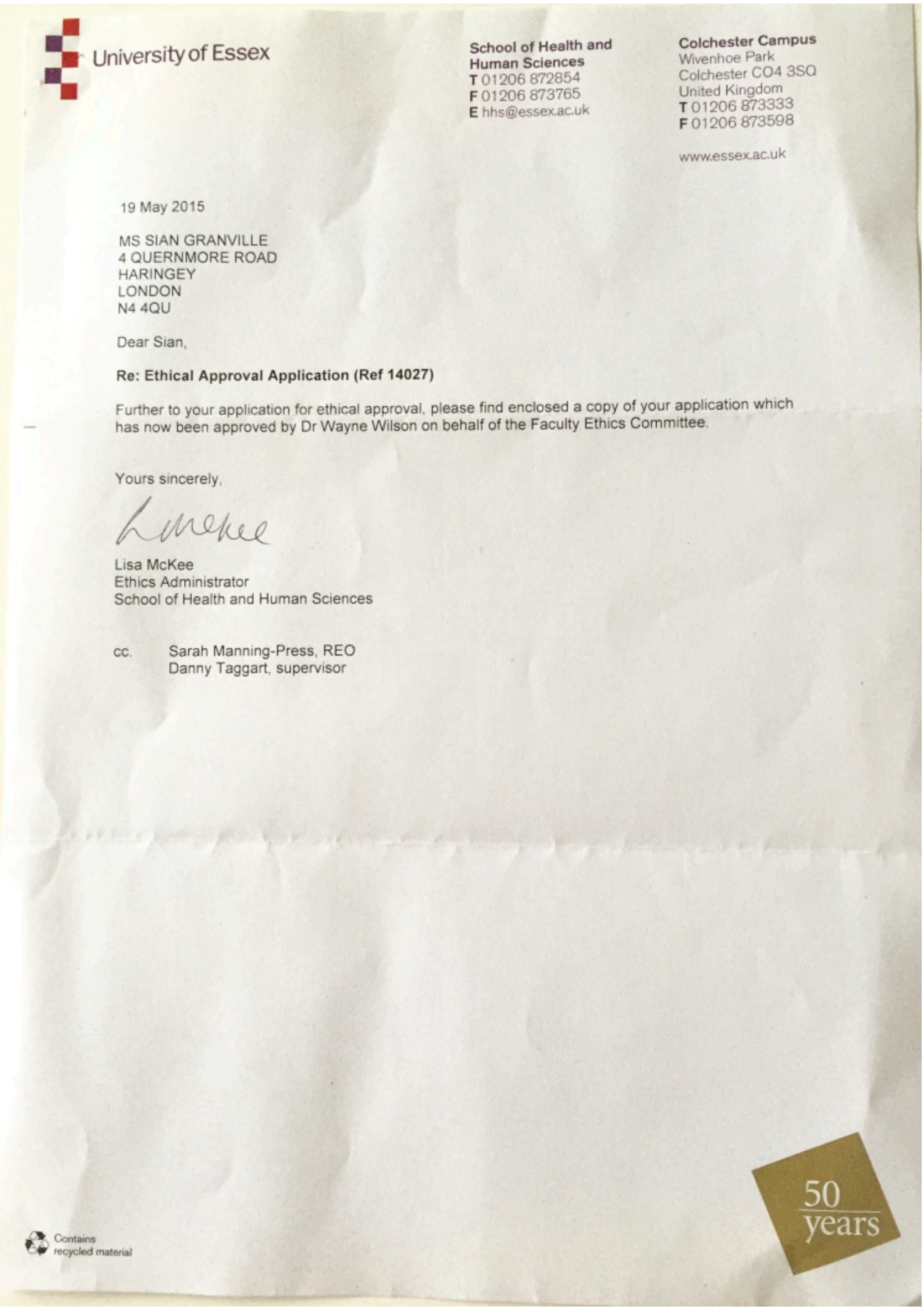
If you have any queries regarding this or any other project, please contact, Tom Rhodes, Senior Research Facilitator, at the above address.

Yours sincerely,

**Dr Bonnie Teague**
**Research Manager**

Chair: Gary E Page
Acting Chief Executive: Andrew Hopkins
Trust Headquarters: Hellesdon Hospital,
Drayton High Road, Norwich, NR6 5BE
Tel: 01603 421421 Fax: 01603 421440 www.nsft.nhs.uk

Ethical approval for the study from the University of Essex ethics committee



University of Essex

**School of Health and Human Sciences**
**T** 01206 872854
**F** 01206 873765
**E** hhs@essex.ac.uk

**Colchester Campus**
Wivenhoe Park
Colchester CO4 3SQ
United Kingdom
**T** 01206 873333
**F** 01206 873598

www.essex.ac.uk

19 May 2015

MS SIAN GRANVILLE
4 QUERNMORE ROAD
HARINGEY
LONDON
N4 4QU

Dear Sian,

**Re: Ethical Approval Application (Ref 14027)**

Further to your application for ethical approval, please find enclosed a copy of your application which has now been approved by Dr Wayne Wilson on behalf of the Faculty Ethics Committee.

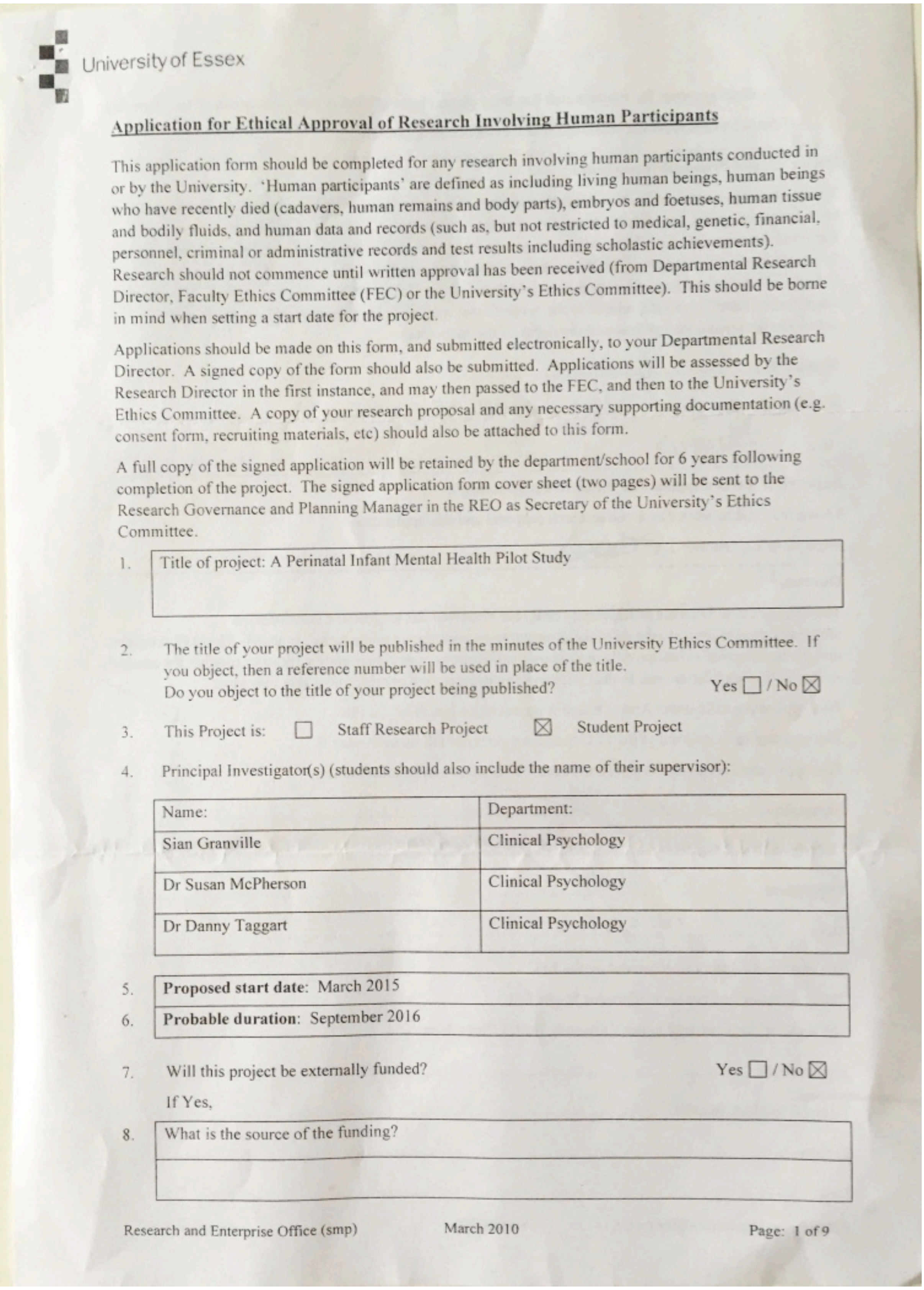
Yours sincerely,

Lisa McKee
Ethics Administrator
School of Health and Human Sciences

cc. Sarah Manning-Press, REO
Danny Taggart, supervisor

Contains recycled material

50 years



University of Essex

## Application for Ethical Approval of Research Involving Human Participants

This application form should be completed for any research involving human participants conducted in or by the University. 'Human participants' are defined as including living human beings, human beings who have recently died (cadavers, human remains and body parts), embryos and foetuses, human tissue and bodily fluids, and human data and records (such as, but not restricted to medical, genetic, financial, personnel, criminal or administrative records and test results including scholastic achievements). Research should not commence until written approval has been received (from Departmental Research Director, Faculty Ethics Committee (FEC) or the University's Ethics Committee). This should be borne in mind when setting a start date for the project.

Applications should be made on this form, and submitted electronically, to your Departmental Research Director. A signed copy of the form should also be submitted. Applications will be assessed by the Research Director in the first instance, and may then passed to the FEC, and then to the University's Ethics Committee. A copy of your research proposal and any necessary supporting documentation (e.g. consent form, recruiting materials, etc) should also be attached to this form.

A full copy of the signed application will be retained by the department/school for 6 years following completion of the project. The signed application form cover sheet (two pages) will be sent to the Research Governance and Planning Manager in the REO as Secretary of the University's Ethics Committee.

1. Title of project: A Perinatal Infant Mental Health Pilot Study

2. The title of your project will be published in the minutes of the University Ethics Committee. If you object, then a reference number will be used in place of the title.
Do you object to the title of your project being published? Yes ☐ / No ☒

3. This Project is: ☐ Staff Research Project ☒ Student Project

4. Principal Investigator(s) (students should also include the name of their supervisor):

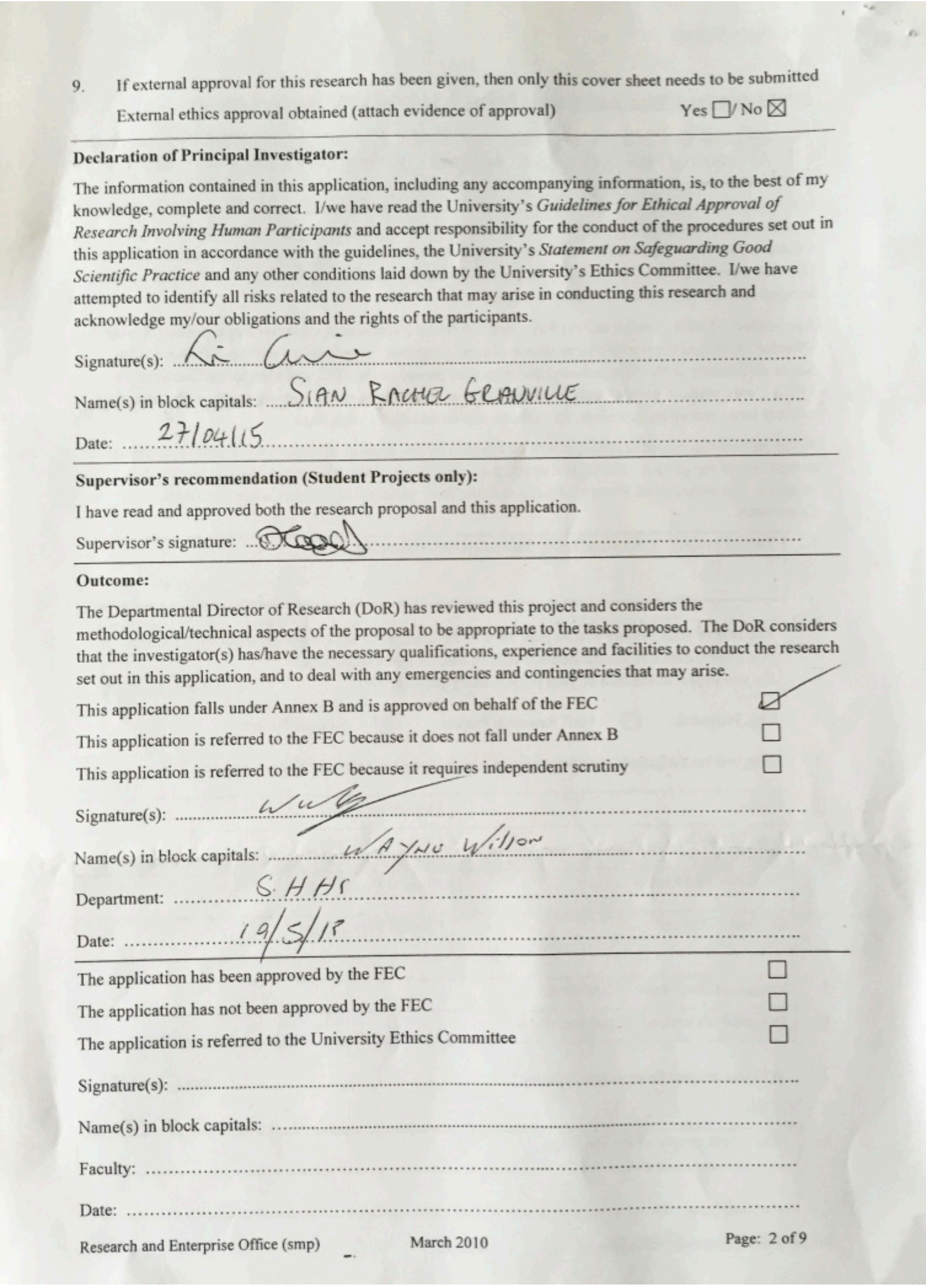
| | |
|---|---|
| Name: | Department: |
| Sian Granville | Clinical Psychology |
| Dr Susan McPherson | Clinical Psychology |
| Dr Danny Taggart | Clinical Psychology |

5. **Proposed start date**: March 2015

6. **Probable duration**: September 2016

7. Will this project be externally funded? Yes ☐ / No ☒
If Yes,

8. What is the source of the funding?



9. If external approval for this research has been given, then only this cover sheet needs to be submitted

External ethics approval obtained (attach evidence of approval) Yes ☐/ No ☒

**Declaration of Principal Investigator:**

The information contained in this application, including any accompanying information, is, to the best of my knowledge, complete and correct. I/we have read the University's *Guidelines for Ethical Approval of Research Involving Human Participants* and accept responsibility for the conduct of the procedures set out in this application in accordance with the guidelines, the University's *Statement on Safeguarding Good Scientific Practice* and any other conditions laid down by the University's Ethics Committee. I/we have attempted to identify all risks related to the research that may arise in conducting this research and acknowledge my/our obligations and the rights of the participants.

Signature(s): ..........

Name(s) in block capitals: SIAN RACHEL GRANVILLE

Date: 27/04/15

**Supervisor's recommendation (Student Projects only):**

I have read and approved both the research proposal and this application.

Supervisor's signature: ..........

**Outcome:**

The Departmental Director of Research (DoR) has reviewed this project and considers the methodological/technical aspects of the proposal to be appropriate to the tasks proposed. The DoR considers that the investigator(s) has/have the necessary qualifications, experience and facilities to conduct the research set out in this application, and to deal with any emergencies and contingencies that may arise.

This application falls under Annex B and is approved on behalf of the FEC ☑

This application is referred to the FEC because it does not fall under Annex B ☐

This application is referred to the FEC because it requires independent scrutiny ☐

Signature(s): ..........

Name(s) in block capitals: WAYNE Wilson

Department: S.HHS

Date: 19/5/15

The application has been approved by the FEC ☐

The application has not been approved by the FEC ☐

The application is referred to the University Ethics Committee ☐

Signature(s): ..........

Name(s) in block capitals: ..........

Faculty: ..........

Date: ..........

Research and Enterprise Office (smp) March 2010 Page: 2 of 9