Minding the Baby: The challenges of implementing a reflective functioning programme with high-risk families

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Thesis declaration form

I confirm that the work presented in this thesis is my own. Where information has been derived from other sources, I confirm that this has been indicated in the thesis.

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Overview

Part 1: Literature Review: This section consists of a meta-analytic review examining the efficacy of video-feedback interventions aimed at promoting parental sensitivity and infant attachment. Outcomes from 18 RCTs contributing 20 intervention effects were examined. Results indicated that video-feedback interventions are efficacious in promoting parental sensitivity, infant attachment security and preventing infant attachment disorganisation. These findings suggest that video-feedback interventions may offer exciting potential for clinical practice.

Part 2: Empirical Paper: The empirical paper reports on a qualitative study examining the challenges of implementing 'Minding the Baby' (MTB), a preventative parenting programme developed explicitly to promote secure parent-child attachment relationships. Semi-structured interviews were conducted with 13 practitioners delivering the programme. Transcripts were analysed thematically and themes were organised into two domains relating to the challenges of implementation and the components of MTB which practitioners identified as being crucial in engaging mothers in reflective work. Results highlight the importance of designing and delivering services which support mentalisation throughout. In addition, a strong therapeutic relationship was identified to be crucial in engaging mothers in reflective work and in responding to the challenges of implementing a mentalisation-based parenting intervention. The study was conducted in collaboration with another UCL Clinical Psychology doctoral student, whose thesis examines parents' experiences of the therapeutic process in MTB (Burns, 2014).

Part 3: Critical Appraisal: The critical appraisal reflects on the process of executing the research presented in Part Two. Firstly, the transportation of interventions is discussed, with consideration of the balance between ensuring model fidelity and the need for adaptation to meet local needs. Finally, the issues in conducting the interviews with practitioners and carrying out qualitative analysis are considered.

Table of contents

List of Tables and Figures

Part 1: Literature Review **Page**

Part 2: Empirical Paper

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Part 1: Literature Review

Efficacy of Video-Feedback Interventions for Promoting Parental Sensitivity and Infant Attachment: A Meta-Analysis

Abstract

Aims: Video-feedback techniques are increasingly being incorporated into attachment-based interventions for parents and their infants. This review aimed to examine the efficacy of interventions which utilise video-feedback with regards to promoting parental sensitivity and enhancing infant attachment security and organisation.

Method: Systematic electronic searches were conducted in order to identify relevant randomised-controlled trials that examine the efficacy of video-feedback interventions. Studies were required to include at least one validated measure of parental sensitivity and/or infant attachment security, based on direct observation of mother-infant interaction. Methodological quality of the studies was assessed using Cochrane criteria.

Results: Eighteen RCTs were identified, contributing 20 intervention effects for parental sensitivity and/or child attachment. Video-feedback interventions were found to be significantly effective at promoting parental sensitivity ($d = 0.41$, $k = 17$) and infant attachment security ($d = 0.25$, $k = 12$) and at preventing infant attachment disorganisation ($d = 0.37$, $k = 7$). No significant moderators were identified.

Conclusions: Video-feedback interventions are efficacious in promoting parental sensitivity, infant attachment security and preventing infant attachment disorganisation. These findings suggest that video-feedback interventions may offer exciting potential for clinical practice, especially as they are brief and relatively low cost to implement. It is of particular clinical importance that video-feedback interventions have been shown to be efficacious at preventing disorganised infant attachment, although there is an urgent need for further development of interventions which specifically target known determinants of disorganisation.

Introduction

Attachment theory suggests that the earliest years of a child's life are critical for later development. Bowlby (1969) proposed that infants are biologically predisposed to form relationships - to use their parent as a source of safety, protection and comfort at times of threat or distress and as a secure base from which to explore the environment. Infants' experiences of using their parents in such ways are thought to form the basis for the development of internal working models or mental representations of relationships (Bowlby, 1998).

A central understanding within attachment theory is that the quality of the attachment relationship is largely determined by the parent's ability to accurately perceive and interpret their infant's signals and respond to them appropriately and promptly, a capacity termed 'maternal sensitivity' by Ainsworth (Ainsworth, Blehar, Waters & Wall, 1978). Secure attachments (e.g. where infants generally protest their caregiver's departure, seek proximity and are comforted when reunited or at times of stress) are likely to develop when infants experience such sensitive care. These infants are thought to develop internal working models of themselves as being competent and loveable and of others as being dependable, available and consistent. However, infants who experience rejecting, inconsistent and insensitive care are likely to develop insecure patterns of attachment; these infants are thought to learn that other people cannot be relied upon to help them feel secure or safe. When parents are rejecting or unresponsive to their infant's signals, the infant often develops an insecure-avoidant attachment, where expressions of need or distress are minimised. In contrast, when parents are inconsistently responsive to their child's signals, the child is likely to develop an insecure-resistant attachment. These infants tend to exhibit clingy and demanding behaviour, and struggle to be soothed. For insecurely attached children,

behaviour is thought to be organised to increase the likelihood that their parents will be responsive when needed - to keep already rejecting parents close, or to ensure the constant attention of an inconsistent parent. However, when parents display behaviour that is extremely insensitive, frightened or frightening, infants often develop disorganised patterns of attachment. These infants lack a coherent, organised strategy for their behaviour at times of stress or threat, as their parent is both the source of fear and the potential for safety (Main & Hesse, 1992; Schuengel et al., 1999).

In support of the proposition that parental sensitivity is instrumental in the development of secure attachments, meta-analytic methods investigating the parental antecedents of attachment security have demonstrated a moderately strong association between sensitivity and attachment, suggesting that parental sensitivity has an important, although not exclusive, influence on attachment security (De Wolff & Van IJzendoorn, 1997).

There is much debate regarding the link between attachment quality in infancy and later socio-emotional development and psychopathology. Despite substantial research in this area, the evidence is often inconsistent and contradictory (Goldberg, 1997). Longitudinal studies have shown that secure attachment relationships in infancy are associated with significantly fewer behavioural problems (Sroufe, Egland, Carlson & Collins, 2005), a reduced risk of school under achievement, and a lower risk of the development of psychopathology (Carlson, 1998; Moss & St-Laurent, 2001; NICHD Early Child Care Research Network, 2005). Similarly, insecure attachments in infancy have been shown to be associated with less optimal socio-emotional functioning (Bretherton, 1985; Sroufe, 1988). In a recent series of meta-analyses, it was demonstrated that insecure (including disorganised) attachments are significantly associated with lower peer competency (Groh et al., 2014) and an

increased risk of both externalising and internalising problems (Fearon, Bakerman-Kranenburg, Van IJzendoorn, Lapsley, & Roisman, 2010; Groh, Roisman, Van IJzendoorn, Bakermans-Kranenburg & Fearon, 2012). Furthermore, disorganised attachment has consistently been shown to be a significant risk factor for later psychopathology (Lyons-Ruth & Jacobvitz, 2008; Moss, Cyr, Bureau, Tarabulsy, & Dubois-Comtois, 2005; Van IJzendoorn, Schuengel, & Bakermans-Kranenburg, 1999).

Types of attachment intervention

Given the importance of early attachment relationships for later development, efforts have been made to investigate whether attachment security can be enhanced, with a focus on early, family-based, preventative programmes.

The range of interventions based on attachment theory is wide. Egeland, Weinfield, Bosquet & Cheng (2000) distinguished four separate types: delineating those which seek to enhance parental sensitivity at the behavioural level, those designed to alter parents' mental representations, those that provide and enhance social support and finally those designed to enhance maternal mental health and well-being. Frequently any one intervention may use a combination of these approaches. Most commonly, the two major approaches adopted are behaviour orientated (e.g. sensitivity training) and representation orientated, as infant-parent attachment has been linked to both parental sensitivity and parent's mental representations of attachment (De Wolff & Van IJzendoorn, 1997).

Interventions with a behavioural focus aim to enhance infant attachment security by enhancing parental sensitivity. This frequently involves helping parents to improve their observation skills, follow their baby's cues and enhance their understanding of the needs of their infant, thus reducing misinterpretations of their

signals. Parents are then supported to select and implement appropriate and sensitive responses to their infant's signals. Positive parental behaviour and sensitive interactions are often also reinforced (e.g. VIPP: Video-feedback Intervention to Promote Positive Parenting; Juffer, Bakermans-Kranenburg & Van IJzendoorn, 2007).

In contrast to the 'here-and-now' focus of behaviourally orientated programmes, representationally orientated interventions focus on parents' own attachment histories. It has been suggested within attachment research that maternal insensitivity to infants' signals is often a function of the caregiver's own unmet attachment needs, stemming from their own early attachment relationships. Fraiberg, Adelson and Shapiro (1975) discuss the intergenerational transmission of trauma, describing how 'ghosts in the nursery' can have significant impact on families, where past experiences are often repeated across generations.

The idea that parents' own attachment experiences and attachment representations impact the attachment security of their infant has been demonstrated empirically; for example, meta-analyses have shown that insecure parents are more likely to have insecurely attached infants than secure parents (Van IJzendoorn, 1995). Parental representations of attachment are hypothesised to determine parents' sensitive responsiveness (which in turn affects infant attachment). Therefore, representationally orientated interventions attempt to enhance child attachment security by targeting the parents' ability to reflect on their own childhood experience and explore the link between those experiences and their developing relationship with their own child.

Evidence for attachment-based interventions

Several previous reviews and meta-analyses have examined the impact attachment-based interventions have on parental sensitivity and infant attachment. Overall, it has been consistently shown that infant attachment security can be enhanced by such parenting interventions (Bakermans-Kranenburg, Van IJzendoorn & Juffer, 2003; Egeland et al. 2000; Van IJzendoorn, Juffer & Duyvesteyn, 1995). Meta-analytical results suggest that randomised interventions are fairly successful in increasing children's attachment security (d = 0.20), but have a larger impact on parental sensitivity (d = 0.33) even in clinical and multi-problem families (Bakermans-Kranenburg et al., 2003). However, it is important to move beyond examining the generic effects of these interventions towards examining the characteristics of interventions that are most effective, and the populations they are most effective for.

In the most comprehensive meta-analysis examining attachment interventions to date, Bakermans-Kranenburg et al. (2003) conclude, based upon examination of 88 intervention effects for parental sensitivity and/or infant attachment security, that the most effective interventions are brief (up to 16 sessions) and have a clear behavioural focus (as opposed to examining parental representations or offering support), leading to the conclusion that 'less is more' when it comes to attachment-based interventions. In further analysis, Bakermans-Kranenburg et al. (2003) found that the same intervention characteristics are as favourable for multi-problem (including clinically referred) families as for lower-risk families, suggesting that the same kinds of intervention work best, irrespective of the level of complexity or risk in the sample. Furthermore, moderator analyses found that the majority (all but two) of the investigated sample characteristics (such as SES, prematurity, adolescent mothers) were not associated with significant differences in effect sizes. The only exceptions

were that interventions conducted with clinically referred samples had a greater effect on parental sensitivity and interventions conducted with samples with a high percentage of insecurity in the control group achieved larger effects on infant attachment, compared to more normative samples.

Whereas parental sensitivity is predictive of organised attachment security, insensitivity alone is not strongly associated with disorganised attachment (Van IJzendoorn et al., 1999). Instead, frightening or frightened parental behaviour has been shown to be associated with disorganisation (Main & Hesse, 1990; Schuengel, Bakermans-Kranenburg, & Van IJzendoorn, 1999; True, Pisani, & Oumar, 2001). In addition, research has shown that children who experience early adversity, such as neglect, abuse or separation from caregivers, are at increased risk for developing disorganised attachments (Carlson, 1998; Lyons-Ruth, Connell, Zoll, & Stahl, 1987; Stovall-McClough & Dozier, 2004; Van IJzendoorn et al., 1999). Very few interventions have been designed to prevent attachment disorganisation; rather the majority tend to target children's insecure, organised attachments. In a separate meta-analysis, Bakerman-Kranenburg, Van IJzendoorn & Juffer (2005) review 15 preventative interventions that include infant attachment disorganisation as an outcome. The overall effect was not significant (d = 0.05); suggesting that more needs to be done to develop interventions that specifically target the prevention of disorganisation. Although the overall effect was not significant, some interventions were successful in preventing disorganised attachments. These interventions tended to be sensitivity-based, start after the infant was 6 months old and involve samples with high-risk children (e.g. adopted infants, highly irritable infants, premature infants), rather than high-risk parents (e.g. impoverished, socially isolated, insecure attachment classification).

Video-feedback interventions

In the 'less is more' meta-analysis, Bakermans-Kranenburg et al. (2003) also reported that interventions which included video-feedback techniques had greater positive effects on parental sensitivity; eight of the included RCTs examined video-feedback interventions, these interventions were more effective in enhancing parental sensitivity (d = 0.44) than those that did not include video-feedback (d = 0.36). Paradoxically, video-feedback interventions were not found to be more effective at influencing infant attachment security, in fact the converse was shown; interventions which included video-feedback were significantly less effective (d = 0.07) than those that did not (d = 0.25). However, the number of interventions that both utilised video-feedback and included measures of infant attachment security was small.

The evidence base for the effectiveness of video-feedback interventions is developing. The exact methods of using video-feedback vary between practitioners and programmes, resulting in difficulties determining the effectiveness of video-feedback interventions as a whole. Lots of different programmes have been developed which frequently use similar techniques (e.g. VIPP: Video-Feedback Intervention to promote Positive Parenting; VIG: Video Interaction Guidance; ABC: Attachment and Bio-behavioural Catch-up). Essentially, in this context, video-feedback involves making a recording of the interaction between a parent and their child, and then encouraging the parent to review the recording and reflect on the content. The exact nature of the focus of the recording and subsequent reflection varies, but most commonly centre on examining parental behaviour (with the aim of drawing attention to and reinforcing positive behaviour) or retrospectively exploring the parent's inferences about the underlying mental or motivational states of their infant during a specific moment.

There is only one previous meta-analytical review examining the efficacy of video-feedback interventions with parents. Fukkink (2008) reports data from 29 video-feedback intervention studies, demonstrating positive changes in both parent and child behaviour, alongside improvements in parents' attitudes towards parenting. However, there is a need for further meta-analytic examination for several reasons. Firstly, the Fukkink (2008) review included studies which failed to meet stringent methodological criteria (e.g. random assignment to conditions took place in only 13 of the 29 included studies, and eight included studies did not involve a control group) and did not include assessments of the methodological quality or risk of bias within the included research – thus limiting the validity of conclusions. Secondly, the previous review had a much broader focus – examining the impact of video-feedback interventions on improving parent and child behaviour, and parents' attitudes towards parenting. The effects on parental sensitivity were not differentiated from the effects on other parental behaviours in the analysis (e.g. "parental behaviour" consisted of measures of parental sensitivity alongside many other constructs such as co-operation, emotional-affective support, instances of looking at the child, and linguistic development stimulation). Similarly, the effects on infant attachment security were not discriminated from other measures of "child behaviour", which included assessments of problem behaviours, receptive language skills and instances of crying. Therefore it is not possible to draw any conclusion about the efficacy of video-feedback interventions at enhancing parental sensitivity or child attachment specifically. Furthermore, some of the included studies delivered interventions which did not explicitly aim to promote parental sensitivity and/or infant attachment security, for example, one study focussed on reducing over-stimulation in children with disabilities, whist another aimed to improve child development with a similar sample. Moreover, a number of included studies delivered

interventions to children with atypical development (e.g. children with moderate-severe learning disabilities and other developmental disorders), or to older children (up to a mean age of 8 years old). Finally, numerous randomised intervention studies have been completed since the publication of the previous review.

The current review

The current review focused on the efficacy of video-feedback interventions designed to promote parental sensitivity and child attachment security in pre-school populations exclusively. The current review was also limited to RCTs and assessed the risk of bias of studies using Cochrane criteria. Given the association with negative child outcomes and the development of psychopathology, the review also examined the effectiveness of video-feedback interventions for preventing disorganised attachments.

This meta-analytic review aimed to address the following questions:

1. Are video-feedback interventions effective in promoting parental sensitivity and infant attachment security and in preventing disorganised infant attachment?
2. Are video-feedback interventions which are more successful in enhancing parental sensitivity also more effective in enhancing infant attachment security?
3. Are some types of intervention better than others; is there a relationship between program characteristics (duration, focus, timing of delivery) and outcomes?
4. Are video-feedback interventions more effective for some parents or some infants; is there a relationship between sample characteristics (level of infant and maternal risk, economic adversity, history of maltreatment) and outcomes?

Method

Search Strategy

Three strategies were used to identify relevant research studies. Firstly, the electronic databases PsychInfo and Medline were systematically searched for studies examining parenting interventions which utilise video-feedback techniques. Secondly, the reference lists of identified articles were reviewed to locate any studies that were not identified during the electronic search. Finally, relevant previous reviews regarding video-feedback techniques were consulted. These reviews were identified from the reference lists of identified articles and through consulting the Cochrane database.

Systematic searches of the PsychInfo and Medline databases were conducted and results were limited to those with human participants, written in the English language and published in peer review journals. Initial searches focused on identifying studies that investigated the use of video-feedback techniques in parenting interventions. However, during keyword, title and abstract searches, terms such as "video-feedback" and "video-guidance" failed to identify relevant studies; frequently the nature of the parenting intervention under investigation was not adequately described in the abstract, and therefore many relevant papers were missed. The search was therefore expanded to include all attachment parenting interventions, regardless of whether or not the terms "video-feedback" or "video-guidance" appeared in the abstract. Adding an additional video-feedback component to the final search yielded further relevant studies not picked up with attachment terms. To maximise specificity and the relevance of papers returned, the final search terms delineated several key concepts; attachment focus, parenting intervention, and video-feedback intervention. Keywords were first entered separately and were subsequently combined (see Table 1).

Table 1

Electronic search terms

Search term category	Terms applied	Combined with
Attachment	Attachment Sensitivity responsiveness* mother infant psychotherapy parent infant psychotherapy	OR
Parenting Intervention	intervent* or prevent* or therap* infan* or child* or toddler* or baby or babies parent* or mother* or maternal	AND
Video-feedback	video* adj4 (feed?back* or guidance or intervention*) infan* or child* or toddler* or baby or babies parent* or mother* or maternal	AND

AND

OR

? and * denote truncation – they replace any number of characters and are an efficient way to look for variant spellings of words. For example; therap* finds therapy, therapies, therapists, therapists, therapeutic, therapeutically etc. ADJ is a positional operator which locates records which contain both search terms adjacent to each other; ADJ followed by a number (e.g ADJ4) returns records which contain both search terms within the specified number of searchable words of each other (e.g. four). AND is a Boolean operator that locates records containing all of the specified terms. OR is a Boolean operator that locates records containing any of the specified terms

Inclusion and exclusion criteria

Inclusion and exclusion criteria were selected in order to maximise the quality of included studies, and to match criteria utilized in previous reviews. Studies were selected for inclusion according to the following criteria.

Publication criteria: The search criteria narrowed inclusion of intervention studies to those published before December 2013, written in the English language and published in peer-reviewed journals.

Design: Studies were included if they were randomised-controlled trials. All other designs (e.g. non-randomised/quasi-experimental) were excluded.

Participants: Studies were selected if the intervention started before infants were aged on average 54 months, as this was the age range utilised in previous reviews (Bakermans-Kranenburg et al., 2003). Interventions with birth parents, adopted parents or foster parents were included. Studies that involved other adults, such as child-minders (e.g. Groenevelt, Van IJzendoorn & Linting, 2011), were excluded as those adults were assumed not to be the infant's primary care giver. There were no restrictions with regards to social-economic status, clinical populations or at-risk populations.

Interventions: Intervention studies that aimed to enhance positive parental behaviour, such as sensitivity, and/or child attachment security were included in the review if they contained one or more session(s) of an intervention which utilised video-feedback techniques. In this context, video-feedback involves making a recording of the parent-child interaction, and then allowing the parent to review the recording and reflect on the content. Therefore studies which utilised video instructions, vignettes or used video

as a means to impart information about child development were not included (e.g. Carvalho, Linhares, Padovani & Martinez, 2009; Constantino et al., 2001; Gardener, Burton & Kiles, 2006; Petch, Halford, Creedy & Gamble, 2012). There were no restrictions with regards to characteristics of the control group/comparative intervention of included studies (e.g. comparative active interventions, treatment as usual, non-active control [e.g. wait-list control/no intervention] were all included).

Outcome measures: Due to the current review's focus on parental sensitivity and infant attachment security, in order to be included intervention studies needed to use either a validated measure of parental sensitivity or infant attachment. The method for measuring both parental sensitivity and infant attachment needed to involve an observation of the parent-infant interaction (e.g. Ainsworth's sensitivity rating scales; Ainsworth's Strange Situation Procedure). Studies that used non-observational methods of assessment (e.g. attachment diaries, Dozier et al., 2009) were excluded. Observational measures were selected as they provide a more objective measure of behaviour in comparison to relying on parent self-report. In addition, the current review's focus is on interventions that aim to encourage changes in parental behaviour (i.e. sensitivity) rather than changes in parental attitudes, based on the assumption that parental behaviour impacts child attachment security. Therefore our criteria restricted included studies to those that employed observational measures.

Data collection and extraction

Screening and selection

Firstly, all studies were screened for relevance by title and in some instances by abstract. Any study that referred to an attachment or parental-sensitivity based

parenting program was included for further detailed screening. For those included studies, full text articles were obtained and checked against the aforementioned inclusion and exclusion criteria.

Data extraction and coding

Data was collected from the full text articles of all included studies and recorded in a data extraction form. The information collected included details of the sample, the interventions and the outcomes. The data extraction form also included a risk of bias table, (see below) requiring both a summary judgment and evidence for that judgment with regards to the risk of bias in a variety of different areas.

Each intervention study was further coded for several characteristics related to the sample, the intervention and the methodology. Each study was coded for the characteristics of both the parents and their infants with regards to whether they were considered high-risk. This decision was based on the presence of a combination of risk factors (see Zeanah, 2000). For parents these included low SES (when SES was not reported, a default of middle/high was coded), single parenthood, teenage parenthood, parental drug use and being either clinically referred (e.g. due to clinical depression) or referred through social services. In addition, being classified as highly insensitive or having an insecure attachment were also considered parental risk factors in the current review. For infants, risk factors included being fostered or adopted, being born prematurely, being highly irritable, scoring highly for externalising behaviour or having prior experiences of maltreatment (e.g. neglect or abuse).

With regards to the coding system for intervention characteristics, each study was coded according to Egeland et al.'s (2000) taxonomy; interventions were classified as aiming to enhance parental sensitive behaviour, target parental

representations, or a combination of these approaches. This is a distinction utilised in previous reviews (e.g. Bakerman-Kranenburg et al., 2003; Fukkink et al., 2008). The number of sessions and the total length of intervention were also recorded. Finally, each study's methodology was coded for the type of control or comparison group (no intervention, treatment as usual, active comparison intervention).

When reported, relevant effect sizes were also extracted. Where no effect size was reported, other pertinent statistics were extracted so that an effect size could be computed.

Analysis

For each study a standardised effect size was computed. In some cases it was not possible to calculate an effect size on the basis of means and standard deviations or frequencies of attachment classifications, as they were not provided in the study report. In these instances, alternative methods were used to estimate the effect size. Moran, Pederson & Krupka (2005) reported means but not standard deviations for the parental sensitivity measure; in this instance an estimate of effect size was calculated according to methods described by Lipsey & Wilson (2000), from the reported $\chi 2$ statistic, which provided a categorical assessment of change in maternal sensitivity for each intervention. Stein et al. (2006) reported the medians and ranges of two composite measures of parental sensitivity. In this instance, the two outcomes were meta-analytically combined into one effect size, which was estimated from the reported medians and ranges according to the methods described by Hozo, Djulbegovic & Hozo (2005). Bick & Dozier (2013) did not report all necessary statistics due to adopting an alternative analytical approach to examining trajectories of mean

differences at each time point. An accurate estimate of effect size could not reliably be calculated from the data that was reported; therefore the authors were contacted and provided the data necessary to calculate the relevant effect size. In addition, Bakermans-Kranenburg, Juffer & Van IJzendoorn (1998) did not report data regarding attachment security or disorganisation, however in a later meta-analysis by the same authors (Bakermans-Kranenburg et al., 2003) effect sizes for parental sensitivity and attachment were provided for the original study. Therefore these effect sizes were used in the current meta-analysis.

The current review includes 18 papers describing 20 video-feedback intervention studies. One study included two non-video-feedback comparison conditions (Juffer, Bakermans-Kranenburg & Van IJzendoorn 2005); in this case an effect size was calculated with the two comparison groups combined in order to maximise N. Two studies reported two separate video-feedback interventions (Bakermans-Kranenburg et al., 1998; Klein Velderman, Bakermans-Kranenburg, Juffer & Van IJzendoorn, 2006) alongside a non-video-feedback comparison or control group. In these instances separate effect sizes were computed for each video-feedback intervention. In both of these studies, the control groups had to be divided to prevent participants from being counted more than once.

In several cases, outcomes were only presented for insecure classifications combined. Therefore the primarily analysis is focussed on the overall contrast between security and insecurity (comprised of avoidant, resistant and disorganised (where coded) attachments). For those studies which also reported disorganisation, our analysis similarly focussed on the overall contrast between organised (comprised of secure, avoidant and resistant) and disorganised classifications.

Meta-Analysis of effect sizes

The resulting statistics and effect sizes were entered into the Comprehensive Meta-Analysis (CMA; Version 2; Borenstein, Rothstein, & Cohen, 2005) computer programme. Effect sizes were first converted to standard mean differences (Cohen's d; Mullen, 1989), and their standard errors were computed. Significance tests and moderator analyses were performed using random effects models, as it has been argued that they more adequately mirror the heterogeneity in behavioural studies (Hunter & Schmidt, 2000). The results generated from random effects models also show less Type 1 Error and more accurate confidence intervals than fixed effects models, and are therefore a more conservative approach, ensuring more robust conclusions (Hunter & Schmidt, 2000; Schmidt, Oh & Hayes, 2009). Three sets of meta-analyses were conducted, one examining the impact of video-feedback interventions on parental sensitivity, one examining the impact of video-feedback interventions on infant attachment security and another examining the impact on infant attachment disorganisation. For each analysis estimates of combined effect size and 95% confidence intervals were computed. Subsequently, moderator analyses were conducted by comparing combined effect sizes between specific subsets of studies grouped by moderators. Contrasts were only tested when each subset contained at least four studies (Bakermans-Kranenburg et al., 2003). Finally, meta-regressions of effect sizes were conducted for continuous moderator variables using Stata (Version 12; StataCorp, 2011) and the Metareg command (Harbord & Higgins, 2008).

Evidence of Publication Bias

The 'trim-and-fill' approach (Duval & Tweedie, 2000a, 2000b) was used to calculate the effect of potential data censoring or publication bias on the outcome of

the meta-analyses. In this approach, a funnel plot is created, where each study's effect size is plotted against the standard error. The term 'funnel' is applied to the plot as this is the expected shape of the array of data points if no data censoring is present. Studies with a larger number of participants are expected to produce more precise estimates of effect size with smaller standard error. Therefore, as standard error increases, effect size data points should become increasingly spread, resulting in a funnel shape if no data censoring is present. However, in some instances it may be less likely that smaller or non-significant studies are published, known as the "file-drawer" problem (Mullen, 1989). This publication bias is evident when the funnel plot appears to be missing studies in the bottom left-hand corner. The basis of the 'trim-and-fill' method is to 'trim' the k rightmost studies considered to be symmetrically unmatched on the left hand side, and then impute, or 'fill' the missing counterparts to these studies as mirror images of the 'trimmed' outcomes on the left hand side. An adjusted overall effect size and confidence interval can then be computed.

Rosenthal's 'fail-safe N' (Rosenthal, 1979) was also calculated to determine the number of unpublished studies with non-significant results needed to reduce the calculated combined effect size of each meta-analysis to non-significance. Rosenthal (1991, p.106) suggests that a fail-safe number of more than 5k + 10, where k = number of included studies, can be considered an indicator of robustness.

Assessment of risk of bias

Risk of bias was assessed using the approach detailed in the Cochrane Handbook for Systematic Reviews of Interventions (Higgins & Green, 2008). The Cochrane Collaboration's risk of bias tool considers sequence generation (selection bias), allocation sequence concealment (selection bias), blinding of participants and

personnel (performance bias), blinding of outcome assessment (detection bias), incomplete outcome data (attrition bias) and selective outcome reporting (reporting bias) as areas necessary of judgment. The assessment of risk in each of these areas comprises of a judgment (e.g. assessing the risk of bias as 'low risk', 'high risk, or 'unclear risk', with the last judgment indicating either lack of information or uncertainty over the potential for bias) and provides evidence to support each judgment.

Within psychological intervention research, it is rarely possible to conceal group allocation from participants or interveners. Therefore, all of studies included in the current review would automatically rate as high risk of performance bias. As such, an additional rating has been given in this category, specifying whether the comparison/control condition is likely to lead to an expectation of benefit equivalent to that in the experimental group (e.g. an active comparison intervention is likely to lead to an equivalent expectation of benefit for participants, whereas a waitlist control group is not).

Results

Results of the search

The combined electronic searches identified 2,473 studies. These studies were screened by their title and abstract, resulting in the exclusion of 2,395 references. Full-text articles were obtained for the remaining 78 studies, which were reviewed in detail against the inclusion and exclusion criteria.

Several of these studies reported data from a shared cohort of participants, or reported provisional results for an intervention for which full/follow up data had subsequently been published. In these instances the paper included in the review was selected according to the following criteria. Firstly, and most commonly, the study

which published the full dataset (e.g. largest N) was selected for inclusion, as long as it also reported all relevant data for post-intervention outcomes. Similarly, data reported in Juffer, Hoksbergen, Riksen-Walraven & Kohnstamm (1997) and Rosenboom (1994) was later combined and reviewed in Juffer et al. (2005). In this instance, the latter paper was included in the current review. Secondly, the study which reported the most relevant analysis (such as the effectiveness of the intervention with regards to sensitivity and attachment outcomes) was included. For example, Van Zeijl et al. (2006) and Stolk et al. (2008) report data from a shared cohort from the Dutch SCRIPT study; in this instance, the data reported in Van Zeijl et al. (2006) has been included as the analysis for the effectiveness of the intervention at improving parental sensitivity was reported, whilst Stolk et al. (2008) only included supplementary analysis, without the relevant sensitivity data.

In total, 18 intervention studies identified through the electronic searches met all inclusion and exclusion criteria and were included in the review. The references of these papers, alongside the references of other relevant reviews, were hand searched for other potentially eligible studies. 12 studies were identified. It was not possible to obtain the full text of one of the articles, but full-text articles of the remaining 11 studies were reviewed against the inclusion and exclusion criteria. None of these papers met criteria for inclusion. Therefore, in total, the current review reports on data from 18 studies describing 20 interventions using video-feedback techniques aimed at enhancing positive parental behaviours such as responsiveness or sensitivity. The number of studies identified from each source and reasons for exclusion are displayed in Figure 1.

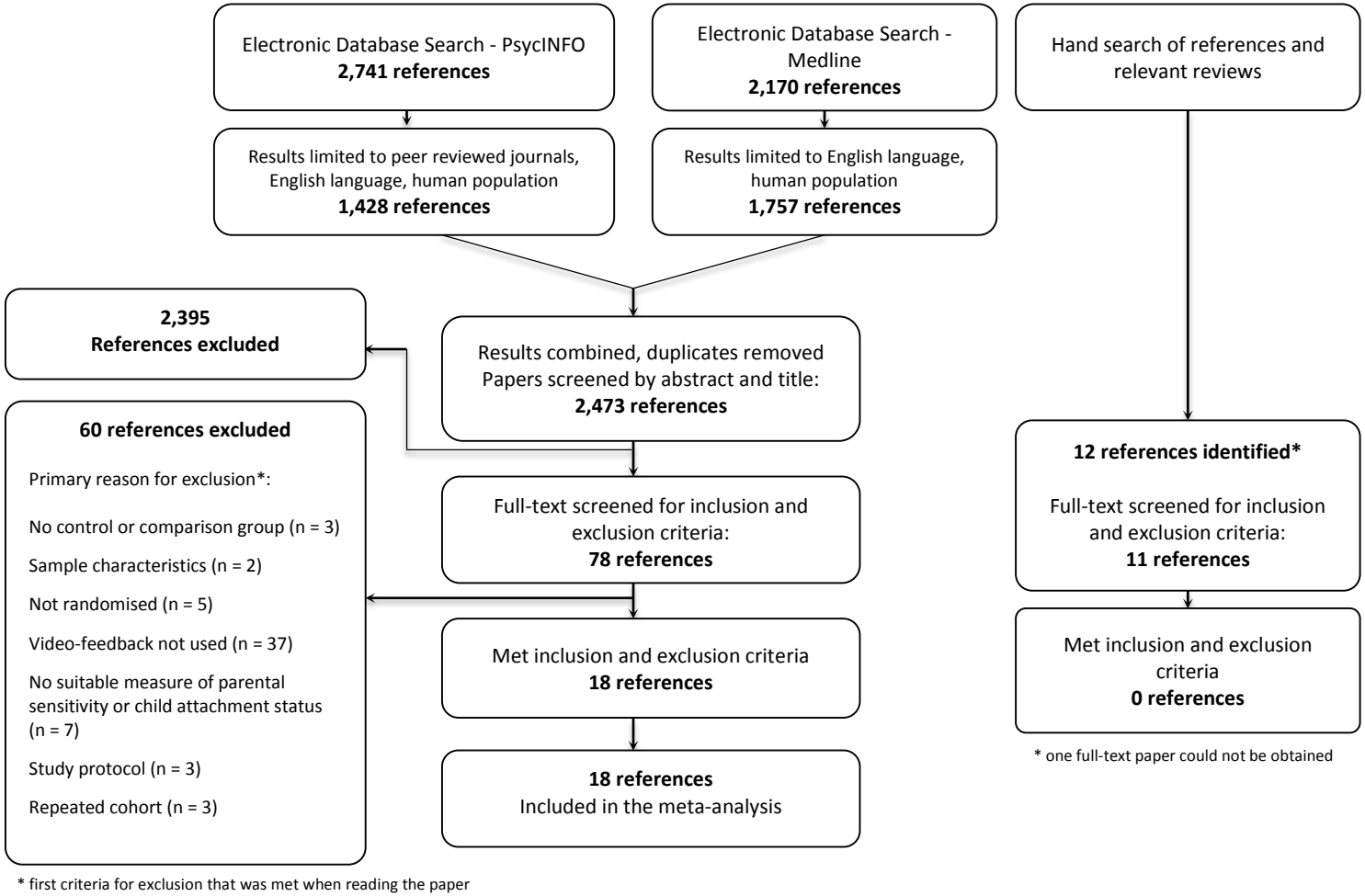

Figure 1. Flow diagram of electronic search strategy

Description of included studies

Design of studies

As a result of the selection criteria, all of the included studies were RCTs comparing a video-feedback intervention to either another active intervention, treatment as usual or a no-intervention control group. Samples varied in size, the smallest being 30 (Bakermans-Kranenburg et al., 1998) and the largest 237 (Van Zeijl et al., 2006), totalling 1, 868 families. Full details of included studies can be found in Table 2.

Sample Characteristics

The majority of studies recruited adult caregivers (mean age range 24.06 – 45) with only two studies (Koniak-Griffin, Verzemnieks & Cahill, 1992; Moran et al., 2005) investigating the effects of video-feedback interventions with adolescent parents (mean age range 17.16 – 18.42). Family's socio-economic status was reported to be low in seven of the studies. The majority of the samples were classified as high-risk; approximately half included high-risk parents, and the other half included high-risk infants. In addition, five studies (Bernard, Dozier, Bick, Lewis-Morrarty & Lindhiem 2012; Bick & Dozier, 2013; Juffer et al., 2005; Moss et al., 2011; Spieker, Oxford, Kelly, Nelson & Fleming, 2012) included children at higher risk of developing disorganised attachment due to experiences of early adversity such as neglect, abuse or early separation from caregivers. However not all of these studies assessed infant attachment disorganisation as an outcome (e.g. Bick & Dozier, 2013; Spieker et al., 2012).

Table 2

Randomised controlled trials of video-feedback interventions and comparative/control treatment efficacy

Author (year)	**Sample Characteristics**	**Video-feedback (VF) intervention components** **Focus - S:** Sensitivity/Behaviour **R:** Representation	**Comparative /control group components**	**Measures***
Bakermans-Kranenburg et al. (1998)	Lower middle-class adult mothers with insecure attachment **Total N** = 30	There were two VF intervention groups: **Video Group**: four sessions of personal VF plus written information about sensitive parenting. (Study 1). **Focus: S** **Video + Discussion Group**: four sessions of personal VF, written information about sensitive parenting plus discussions about mothers' attachment representations. (Study 2). **Focus: S + R**	**No treatment control**: no detail was provided.	Ainsworth's sensitivity scale SSP (ABCD)
Bernard et al. (2012)	Children at risk of maltreatment referred by social services **Total N** = 120	**ABC - Attachment and Bio-behavioural Catch-up**: intervention designed to decrease frightening behaviour and enhance sensitive care amongst parents identified as being at high risk for maltreating their children. Ten sessions - VF was provided in most sessions. Two sessions focused on exploring caregivers own attachment experiences. **Focus: S + R**	**Developmental Education for Families** - designed to enhance cognitive, and especially linguistic, development.	SSP (ABCD)
Bick & Dozier (2013)	Foster carers **Total N** = 96	**ABC - Attachment and Bio-behavioural Catch-up:** ten sessions; as above. **Focus: S + R**	**Developmental Education for Families** – as above.	Ainsworth's sensitivity scale
Brisch et al. (2003)	Preterm infants (<=1500 grams). **Total N** = 87	**Comprehensive program:** consisted of four intervention components: Supportive group psychotherapy (five sessions), attachment-oriented individual psychotherapy (five sessions), one home visit post-discharge, one day extended VF sensitivity training. **Focus: S + R**	**Treatment as usual** from medical team at neonatal unit.	SSP (ABC)
Cassidy et al. (2011)	Highly irritable infants, low SES **Total N** = 220	**The Circle of Security Home Visiting 4 Intervention** (COS-HV4): adapted from the Circle of Security Protocol (COS). COS-HV4 is a four session individual home-visiting intervention consisting of psycho-education about attachment and individual VF focused on maternal sensitivity. **Focus: S**	**Psycho-educational sessions** addressing topics of concern to new parents. Relevant literature also provided.	SSP (ABCD)

Juffer et al. (2005)	Internationally adopted infants **Total N** = 123	**Video-feedback and personal book:** three sessions of individual VF which aimed at enhancing sensitive responsiveness. Parents were also provided with written information in a personalised book (name of child integrated into text), which comprised of suggestions for sensitive parenting and playful interaction. **Focus: S**	There were two non-VF groups. **Personal book**: as before **No intervention control group**: received a book on adoption	Ainsworth's sensitivity scale SSP (ABCD)
Kalinauskiene et al. (2009)	Low sensitivity mothers **Total N:** 54	**VIPP** - video-feedback intervention to promote positive parenting: five sessions - VF was the basis for every session with the aim of reinforcing mothers' sensitive responsiveness to their infants' signals. Additionally, mothers were provided with information on attachment-related issues by giving them brochures about sensitive parenting. **Focus: S**	**Phone intervention** - mothers were contacted by phone and asked for information on their infants' development.	Ainsworth's sensitivity scale AQS
Klein-Velderman et al. (2006)	Insecurely attached first-time mothers, high-risk sample. **Total N:** 81	The efficacy of two different VIPP (video-feedback intervention to promote positive parenting) interventions was investigated. **VIPP:** four sessions, as above. (Study 1). **Focus: S** **VIPP + R:** VIPP with a representational focus (Study 2)**.** Four sessions **Focus: S + R**	**No intervention control**	Ainsworth's sensitivity scale SSP (ABC)
Koniak-Griffin et al. (1992)	Adolescent mothers, low SES. **Total N** = 31	**Videotape instruction and feedback**. Reviewed a single tape of a structured mother-infant teaching episode and received one session of individualised feedback which emphasised positive maternal behaviour. **Focus: S**	**No intervention Control**	NCAST
Moran et al. (2005)	Adolescent mothers, low SES, majority single parents **Total N:** 99	**Video-feedback intervention**: eight sessions, aimed at supporting mothers' sensitivity to their infant. VF used in every session, discussion about videos focused on reinforcing strengths and reflecting on infant's motivational states. **Focus: S**	**No intervention control**	MBQS SSP (ABCD)

Moss et al. (2011)	Maltreating families referred by social services. Low SES. High-risk sample. **Total N** = 67	**Intervention Group:** eight sessions which primarily focused on reinforcing parental sensitive behaviour by means of personalised parent–child interaction video-feedback and discussion of attachment and emotion regulation-related themes. Intervention group also received standard agency services. **Focus: S**	**Treatment as Usual**: standard agency services, which consisted of a monthly visit by a child welfare caseworker	MBQS SSP or PSRP depending on infant age (ABCD)
Robert-Tissot et al. (1996)	Clinically referred children. **Total N** =103	**Interaction guidance:** seven sessions. Seeks to encourage positive family interactions through the use of video-assisted coaching methods during parent-infant play. Therapists focus on positives and suggest alternative interpretations for infant's behaviour. **Focus: S**	**Psychodynamic mother-infant psychotherapy** - focus on maternal representations.	Ainsworth's sensitivity scale
Spieker et al. (2012)	Children in state welfare with a recent placement disruption **Total N** = 210	**Promoting First Relationships (PFR):** ten sessions of brief attachment-based intervention. Five-videotaped caregiver–child interactions were used for reflective video-feedback - guided discussion focused on parenting strengths and interpretation of the child's cues. Participants were also provided with handouts, and reviewed two short videos about attachment and relationships. **Focus: S**	**EES – Early Education Support:** three sessions - signposting and suggestions about activities to promote development.	NCAST Toddler AQS-45
Stein et al. (2006)	Clinically referred adult mothers (eating disorder). **Total N = 80.**	**Video-feedback Interactional Treatment** (modified version of Juffer et al., 1997). Thirteen sessions which aim to prevent or reduce mother-infant conflict and enhance mother-child interaction, principally during mealtimes. **Focus: S** PLUS guided CBT self-help for eating disorder	**Supportive Counseling** thirteen sessions PLUS guided CBT self-help for eating disorder	Adapted Ainsworth's sensitivity scale
Suchman et al. (2010)	Clinically referred mothers (substance abuse). Low SES. High levels of psychiatric distress. **Total N** = 47.	**Mothers and Toddlers Program** (MTP): twelve sessions of attachment-based individual parenting therapy. Utilises mentalisation techniques, mothers are also encouraged to explore own representations of herself and others. VF used to encourage mothers to make retrospective inferences about underlying wishes, intentions, and emotions during live interactions. Attachment-based developmental guidance provided. **Focus: S + R** Mothers also received standard care at the substance abuse clinic	**Parent Education Program** twelve sessions of individual case management and written information about behavioural guidance for common issue when caring for infants PLUS standard care	NCAST

Van Doesum et al. (2008)	Clinically referred mothers (clinical depression - 70% had psychiatric co-morbidity) **Total N** = 61.	**Mother-Baby Intervention:** 8-10 home visits. VF was used as the core intervention method. Initially a recording of mother-child interaction was analysed by MDT with a focus on maternal sensitive behaviour. From this analysis individualised goals to increase maternal sensitivity were defined for each mother. **Focus: S**	**Telephone Intervention:** three 15minute telephone calls to provide parenting support	EAS AQS
Van Zeijl et al. (2006)	Infants with high levels of externalising behaviour. **Total N** = 237.	**VIPP-SD:** six sessions of Video-feedback Intervention to Promote Positive Parenting – Sensitive Discipline: The VIPP program was extended to include information and advice regarding sensitive parental discipline in order to prevent and reduce child externalising problems. **Focus: S**	**Phone intervention** six phone calls - mothers were asked for information on their infants' development	Erickson Scales
Zelkowitz et al. (2011)	Preterm infants Mothers – clinical levels of anxiety and depression **Total N** = 122.	**Cues program**: six sessions. Intervention consisting of two major components: maternal anxiety reduction component (2 sessions) and a maternal sensitivity component (4 sessions). **Focus: S**	**Care program**: five sessions & two phone calls – information given on common health problems of preterm infants and infant care	GRS

* **Measures**:

Sensitivity: Ainsworth's sensitivity scales: Ainsworth's Maternal Sensitivity Scale (Ainsworth, Bell & Stayton, 1974); Erickson Scales: Erickson rating scale for maternal sensitivity and supportiveness (Egeland, Erickson, Clemenhagen-Moon, Hiester & Korfmacher, 1990); EAS: Emotional Availability Scales (Biringen, Robinson & Emde, 1998; Bringen, 2000); NCAST: Nursing Child Assessment Satellite Training (Barnard, 1978); MBQS: Maternal Behaviour Q-Sort (Pederson & Moran, 1995); GRS: Global Rating Scales of Mother-Infant Interaction (Murray, Fiori-Cowley, Hooper & Cooper, 1996);

Attachment: SSP: Strange Situation Procedure (Ainsworth 1978) – ABC: x3 way attachment classifications including secure, insecure-resistant and insecure-avoidant, ABCD: x 4 way attachment classification including disorganised attachment; AQS: Attachment Q-Sort (Waters and Deane, 1985); Toddler AQS-45: Toddler Attachment Q-Sort (Kirkland, Bimler, Drawneek, McKim, & Schölmerich 2004); PSRP: Preschool Separation Reunion Procedure (Cassidy et al., 1992)

Characteristics of the video-feedback interventions

All of the included video-feedback interventions were home visiting programmes, with the exception of three; two of which delivered the intervention within a Neonatal Intensive Care Unit (Brisch, Bechinger, Betzler & Heinmann, 2003; Zelkowitz et al., 2011), whilst the third delivered sessions at a Child Guidance Clinic (Robert-Tissot et al., 1996). Video-feedback techniques were a core intervention method throughout the duration of all but one of the interventions; Brisch et al. (2003) provided just one day of video-feedback in addition to five individual and five group therapeutic sessions.

All 20 video-feedback interventions included a behavioural focus aimed to enhance parental sensitivity. In some cases there was an additional focus on reducing parental frightening behaviour (Bernard et al., 2012; Bick & Dozier, 2013), or on exploring parental representations (Bakermans-Kranenburg et al., 1998, study 2; Bernard et al., 2012; Bick & Dozier, 2013; Brisch et al., 2003; Klein Velderman et al., 2006, study 2; Suchman et al., 2010).

Risk of Bias

The summary judgements for each study with regards to risk of selection, performance, detection, attrition and reporting bias can be found in Table 3. Within the majority of studies, no detail was provided about random sequence generation or allocation concealment, resulting in unclear conclusions about the risk of selection bias across most of the included studies. Those that did provide pertinent information reported adequate methods to conclude that there would be a low risk of bias in this area. As is often the case with psychological intervention research, blinding of participants and personnel was not possible, resulting in all included studies being at

high risk of performance bias. For some studies, participants in the control group were provided with a comparable intervention that would more likely result in a similar expectation of benefit to those participants in the experimental condition, however, only one study actually explicitly measured participants' expectations of treatment (Stein et al., 2006). In those studies with a comparable treatment control group, the risk of performance bias is likely to be less than for those studies which compared video-feedback interventions to either no intervention control groups or minimal intervention control groups. Three of the included studies did not report blinding outcome assessors on measures of infant attachment security (Spieker et al., 2012) and/or maternal sensitivity (Kalinauskiene et al., 2009; Moran et al., 2005; Spieker et al., 2012). These measures have a high degree of subjectivity and therefore there is a significantly higher risk of detection bias if the raters were not blind to the group allocation of mothers. However, all other included studies reported adequate blinding of outcome assessors for parental sensitivity and infant attachment security measures. The majority of studies retained a reasonable number of participants throughout the intervention and to follow up, however the number of participants who dropped out at each stage of the research and the reasons for their attrition was not always adequately reported.

Table 3.

Risk of bias judgements for each study

Author (year)	Random sequence generation	Allocation concealment	Blinding – participants	Blinding - personnel	Blinding - outcome assessors	Incomplete outcome data addressed	Selective reporting
Bakermans-Kranenburg et al. (1998) Study 1	Unclear	Unclear	High [1]	High	Low	Unclear	Low
Bakermans-Kranenburg et al. (1998) Study 2	Unclear	Unclear	High [1]	High	Low	Unclear	Low
Bernard et al. (2012)	Unclear	Unclear	High [4]	High	Low	Low	Low
Bick & Dozier (2013)	Unclear	Unclear	High [4]	High	Low	Unclear	Low
Brisch et al. (2003)	Unclear	Unclear	High [2]	High	Low	Low	Low
Cassidy et al. (2011)	Unclear	Unclear	High [4]	High	Low	Low	Low
Juffer et al. (2005)	Unclear	Unclear	High [1, 3]	High	Unclear	Low	Low
Kalinauskiene et al. (2009)	Unclear	Unclear	High [3]	High	Sensitivity Attachment	Low	Low
Klein Velderman et al. (2006) Study 1	Unclear	Unclear	High [1]	High	Low	Unclear	Low
Klein Velderman et al. (2006) Study 2	Unclear	Unclear	High [1]	High	Low	Unclear	Low
Koniak-Griffin et al. (1992)	Unclear	Unclear	High [3]	High	Low	Low	Low
Moran et al. (2005)	Unclear	Unclear	High [1]	High	High	Unclear	Low
Moss et al. (2011)	Unclear	Unclear	High [2]	High	Low	Unclear	Low
Robert-Tissot et al. (1996)	Unclear	Unclear	High [4]	High	Low	Unclear	Low
Spieker et al. (2012)	Low	Unclear	High [3]	High	High	Unclear	Low
Stein et al. (2006)	Low	Low	High [4]	High	Low	Low	Unclear
Suchman et al. (2010)	Unclear	Unclear	High [4]	High	Low	Low	Low
Van Doesum et al. (2008)	Low	Unclear	High [3]	High	Low	Unclear	Low
Van Zeilj et al. (2006)	Low	Unclear	High [3]	High	Low	Low	Low
Zelkowitz et al. (2011)	Low	Unclear	High [4]	High	Low	Low	Low

[1] Comparison condition was a non-active control group (e.g. waitlist control, no intervention control)
[2] Comparison condition was treatment as usual
[3] Comparison condition was active but minimal (e.g. providing a book/information, signposting)
[4] Comparison condition was active and of a similar dosage and method of delivery

Intervention effects

Parental Sensitivity

The first meta-analyses examined the impact of video-feedback interventions on parental sensitivity. These analyses included 17 studies involving 1,368 participants. Two studies reported an effect size of zero, however, in the remaining 15 studies positive effects were established (see Figure 2). A significant combined effect size of d = 0.41 was found (95% CI: 0.28, 0.54; p = <.001), suggesting that video-feedback interventions are moderately effective at enhancing parental sensitivity. There was no evidence of statistical heterogeneity (Q = 21.26, p = .168, I^2 = 24.8%).

Study name	Std diff in means	Standard error	Variance	Lower limit	Upper limit	Z-Value	p-Value
Koniak-Griffin et al. (1992)	1.006	0.381	0.145	0.259	1.754	2.638	0.008
Robert-Tissot et al. (1996)	0.613	0.238	0.057	0.147	1.080	2.578	0.010
Bakermans-Kranenburg et al. (1998) Video	0.910	0.572	0.328	-0.212	2.032	1.590	0.112
Bakermans-Kranenburg et al. (1998) Video + R	0.810	0.567	0.322	-0.302	1.922	1.428	0.153
Juffer et al. (2005)	0.350	0.182	0.033	-0.006	0.706	1.928	0.054
Moran et al. (2005)	0.465	0.220	0.048	0.034	0.897	2.113	0.035
Klein Velderman et al. (2006) VIPP	0.460	0.339	0.115	-0.205	1.125	1.355	0.175
Klein Velderman et al. (2006) VIPP R	0.520	0.337	0.113	-0.140	1.180	1.545	0.122
Stein et al. (2006)	0.380	0.230	0.053	-0.071	0.831	1.652	0.098
van Zeilj et al. (2006)	0.000	0.130	0.017	-0.255	0.255	0.000	1.000
Van Doesum et al. (2008)	0.566	0.242	0.059	0.091	1.040	2.337	0.019
Kalinauskiene et al. (2009)	0.780	0.283	0.080	0.227	1.334	2.762	0.006
Suchman et al. (2010)	0.564	0.298	0.089	-0.019	1.147	1.896	0.058
Moss et al. (2011)	0.485	0.248	0.062	-0.001	0.971	1.955	0.051
Zelkowitz et al. (2011)	0.000	0.202	0.041	-0.396	0.396	0.000	1.000
Spieker et al. (2012)	0.385	0.153	0.023	0.086	0.684	2.525	0.012
Bick & Dozier (2013)	0.533	0.208	0.043	0.125	0.942	2.558	0.011

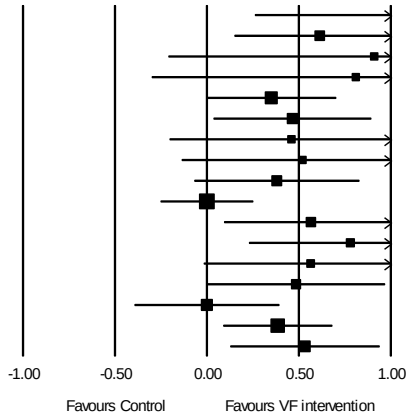

Figure 2. Post-treatment comparative efficacy for parental sensitivity

The failsafe number of studies reporting null results needed to reduce the effect size to non-significance was 231, which exceeds Rosenthal's criterion of 95 (5k +10), providing evidence that the effect size is robust and is not accounted for by the 'file-draw problem'. The trim-and-fill approach was employed to examine whether there was any evidence of publication bias or data censoring. Six studies were trimmed and filled, with a resulting significant combined effect size of d = 0.33 (95% CI: 0.20, 0.46; p< .001; Q= 34.38). The funnel plot created using this method can be found in Figure 3.

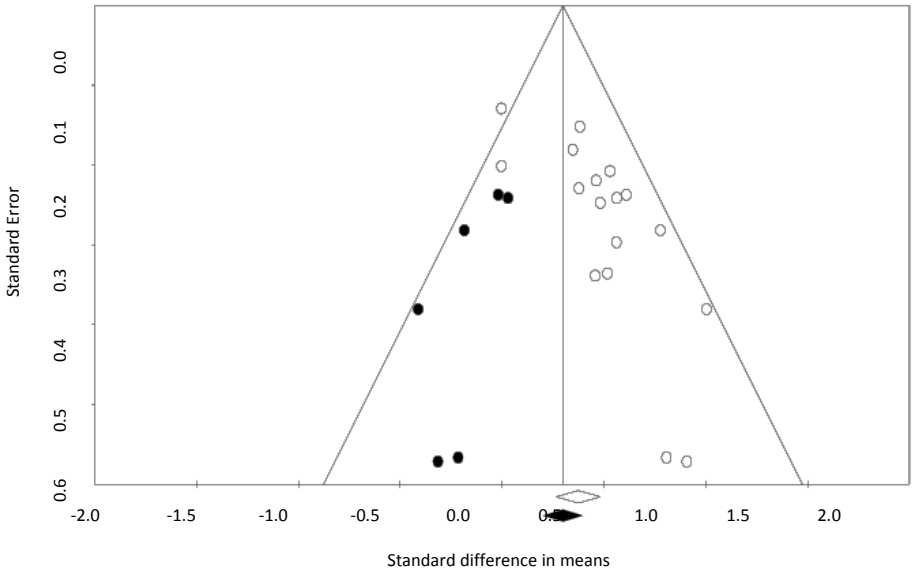

Figure 3. Funnel Plot to Assess Publication Bias for Parental Sensitivity

What interventions are most effective in enhancing parental sensitivity, and who are they most effective for?

Moderator analyses were conducted to examine whether intervention and sample characteristics explained between-study variability in parental sensitivity (see Table 4). None of the investigated moderators were significantly associated with effect size. However, results indicate a tendency for video-feedback interventions to be more effective with samples considered to be low-medium SES (d = 0.59) rather than medium-high SES (d = 0.36), although these differences do not quite reach significance (Q = 2.24, p = 0.13). Similarly, differences in the duration of the intervention (in weeks) was approaching significance (p = 0.08), suggesting that interventions which took place across fewer weeks tended to be more effective than those which took place over a longer period of time. No differences were observed with regards to the number of sessions.

Table 4

Parental Sensitivity: Random-Effects Meta-Analysis and Meta-Regression

	k	*n*	*d*	95% CI	Contrast *Q*	Contrast *p*
Total Set	**17**	**1,368**	**0.41****	**0.28, 0.54**		
Focus					0.93	0.34
Sensitivity	13	1,170	0.40**	0.24, 0.55		
Sensitivity & Representations	4	198	0.60**	0.27, 0.85		
Control group intervention					0.21	0.90
No intervention or TAU	7	407	0.46**	0.26, 0.67		
Minimal intervention	5	568	0.46**	0.12, 0.80		
Comparable intervention	5	393	0.39**	0.16, 0.63		
Number of sessions					0.74	0.39
<5	6	271	0.52**	0.27, 0.78		
≥5	11	1096	0.39**	0.22, 0.55		
Mum High Risk					0.46	0.50
Yes	13	830	0.45**	0.31, 0.59		
No	4	538	0.34*	0.04, 0.64		
Infant High Risk					0.47	0.49
Yes	6	597	0.39**	0.18, 0.59		
No	11	771	0.48**	0.31, 0.64		
Elevated risk of disorganisation					0.02	0.89
Yes	4	468	0.42**	0.24, 0.61		
No	13	900	0.44**	0.25, 0.63		
Infant age					0.40	0.53
< 1 year	12	767	0.45**	0.30, 0.60		
> 1 year	5	601	0.36**	0.10, 0.61		
SES					2.24	0.13
Low-Med	6	274	0.59**	0.34, 0.84		
Med-High	11	1,094	0.36**	0.21, 0.52		

Random-effects meta-regression for parental sensitivity

	k	*n*	*Co-efficient*	95% CI	*SE*	*p*
Year of publication	17	1, 386	-0.187	-0.049, 0.012	0.014	0.21
Number of sessions	17	1, 386	-0.004	-0.056, 0.047	0.024	0.86
Duration of intervention (weeks)	17	1, 386	-0.012	-0.025, 0.002	0.006	0.08

*p < .05. **p < .01.

Infant Attachment

Are video-feedback interventions effective in promoting infant attachment security?

The second set of meta-analyses included 12 studies reporting intervention effects on infant attachment security, involving 934 families (see Figure 4).

Interventions showed varying outcomes with regards to infant attachment security; one study reported negative effects (Brisch et al., 2003) and two reported an effect size of zero (Bakermans-Kranenburg et al., 1998, study 2; Kalinauskiene et al., 2009). However, in the remaining eight studies positive effects were established (see Figure 4). The combined effect size for attachment security was d = 0.25 (95% CI: 0.09, 0.42; p = 0.003). This effect size would need more than 22 studies (fail-safe N) with null results to reduce the effect to non-significance. This failsafe N is smaller than the proposed criterion for robustness (5k + 10 = 75); therefore results should be interpreted with caution. There was no evidence of statistical heterogeneity (Q = 14.602, p = .201, I^2 = 24.67%).

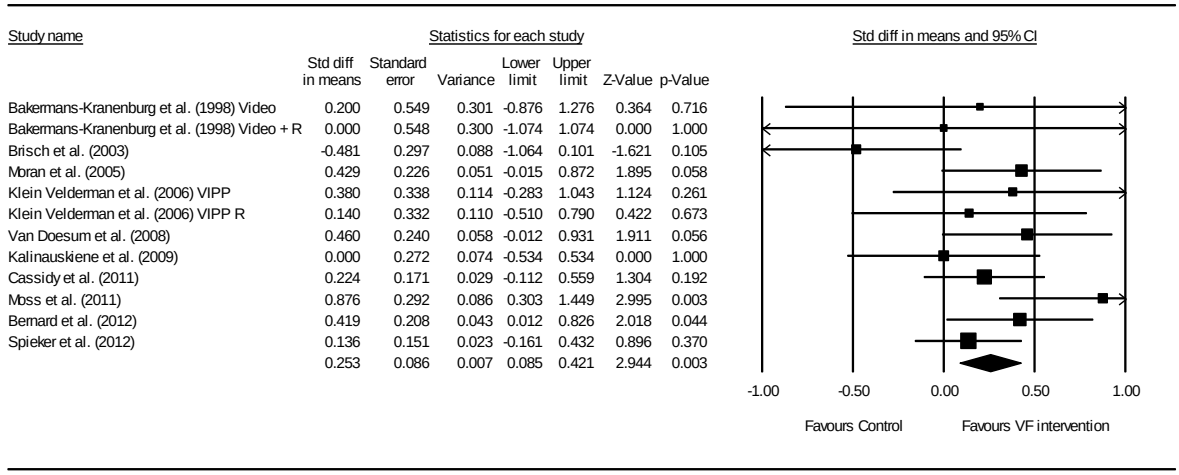

Figure 4. Post-treatment comparative efficacy for infant attachment security

Again, the 'trim-and-fill' approach was used to assess for publication bias (see Figure 5). No studies needed to be trimmed and filled, providing evidence for the absence of the 'file-draw' problem.

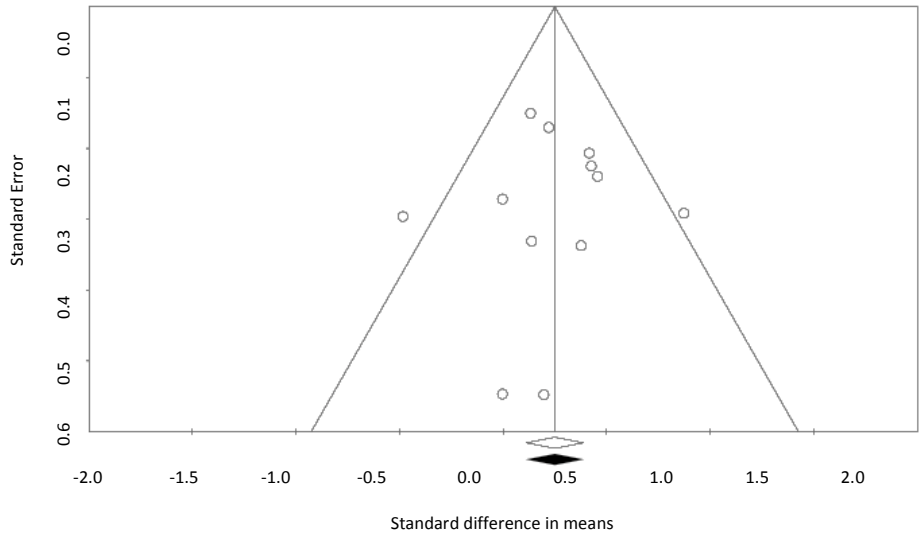

Figure 5. Funnel Plot to Assess Publication Bias for Infant Attachment Security

What interventions are most effective in enhancing attachment security, and who are they most effective for?

Moderator analyses were conducted to examine whether intervention and sample characteristics explained between-study variability in infant attachment security. None of the investigated moderators were significantly related to effect size (see Table 5). However, in keeping with findings for parental sensitivity, interventions delivered to low-medium SES families tended to be more effective (d = 0.39) than those delivered to medium-high SES families (d = 0.12), although again, this difference did not quite reach significance (Q = 2.78, p = 0.1).

For both parental sensitivity and infant attachment security outcomes, the focus of the intervention was not related to effect size. However, the effect sizes for each are interesting as they appear somewhat contradictory. With regards to parental sensitivity, contrary to expectations based on previous meta-analyses (e.g. Bakermans-Kranenburg et al., 2003), results suggest that interventions with a sole focus on parental sensitive behaviour tended to be less effective (d = 0.40) than those which

Table 5.

Infant Attachment Security: Random-Effects Meta-Analysis and Meta-Regression

	k	*n*	*d*	95% CI	Contrast Q^a	Contrast *p*
Total Set	**13**	**934**	**0.25****	**0.09, 0.42**		
Focus					0.99	0.32
Sensitivity	8	691	0.29**	0.13, 0.46		
Sensitivity & Representations	4	243	0.05	-0.40, 0.50		
Control group intervention					-	-
No intervention or TAU	7	345	0.25	-0.10, 0.60		
Minimal intervention	3	300	0.19	-0.04, 0.41		
Comparable intervention	2	289	0.30*	0.04, 0.56		
Number of sessions					0.07	0.79
<5	5	280	0.22	-0.04, 0.48		
≥5	7	654	0.27*	0.01, 0.53		
Mum High Risk					-	-
Yes	10	237	0.31**	0.15, 0.47		
No	2	697	0.80**	-0.77, 0.60		
Infant High Risk					0.07	0.79
Yes	5	599	0.24	-0.08, 0.56		
No	7	335	0.29**	0.06, 0.52		
Elevated risk of disorganisation					-	-
Yes	3	362	0.42**	0.03, 0.81		
No	9	572	0.20**	0.02, 0.38		
Infant age					-	-
< 1 year	10	692	0.23**	0.06, 0.40		
> 1 year	2	242	0.46	-0.26, 1.18		
SES					2.78	0.10
Low-Med	6	485	0.39**	0.18, 0.59		
Med-High	6	449	0.12	-0.12, 0.36		
Parental sensitivity effect size					1.33	0.52
< 0.5	4	382	0.40**	0.09, 0.71		
> 0.5	5	195	0.21	-0.08, 0.50		

Random-effects Meta-regression for Infant Attachment Security

	k	*n*	*Co-efficient*	95% CI	SE	*p*
Year of publication	12	934	0.026	-0.026, 0.079	0.024	0.29
Number of sessions	12	934	-0.041	-0.082, 0.740	0.035	0.91
Duration of intervention (weeks)	12	934	-0.001	-0.046, 0.031	0.017	0.68
Parental sensitivity effect size	9	934	-0.492	-2.191, 1.208	0.719	0.52

*p < .05. **p < .01.

[a] Subgroup with k < 4 excluded from contrast

contained an additional component concentrating on parental representations (d = 0.60), although this difference was not significant (Q = 0.93; p = 0.34). However, with regards to infant attachment security, interventions which only focussed on parental sensitive behaviour tended to be more effective at promoting infant attachment security (d = 0.29) than those that contained an additional component concentrating on parental representations (d = 0.05). Despite a large difference in effect sizes, this difference was again not significant (Q = 0.99, p = 0.32).

We also examined whether or not the interventions which were most effective in enhancing parental sensitivity were also more effective in promoting infant attachment security. Nine studies reported intervention effects on both parental sensitivity and infant attachment security. The effect sizes for parental sensitivity were coded into two categories, those smaller than or equal to 0.5 and those bigger than 0.5. There was no significant difference (Q = 1.33, p = 0.52) between these two categories. In fact, contrary to predictions, the studies with smaller effect sizes for parental sensitivity tended to have larger effect sizes for infant attachment security (d = 0.40, p = 0.01) compared to those with larger effects for parental sensitivity (d = 0.21, p = 0.15).

Are video-feedback interventions effective in preventing disorganised infant attachments?

The final set of meta-analyses examined the impact of video-feedback interventions on infant attachment disorganisation (see Figure 6). These analyses included 7 studies involving 608 participants. The combined effect size for infant attachment disorganisation was moderate and significant (d = 0.37; 95% CI: 0.02, 0.70; p = 0.037). There was evidence of significant statistical heterogeneity within the sample (Q = 13.43, p = 0.037, I^2 = 55.3%).

Study name	Std diff in means	Standard error	Variance	Lower limit	Upper limit	Z-Value	p-Value
Bakermans-Kranenburg et al. (1998) Video	-0.410	0.553	0.306	-1.493	0.673	-0.742	0.458
Bakermans-Kranenburg et al. (1998) Video + R	-0.210	0.549	0.301	-1.286	0.866	-0.382	0.702
Juffer et al. (2005)	0.804	0.361	0.131	0.095	1.512	2.224	0.026
Moran et al. (2005)	0.019	0.224	0.050	-0.420	0.459	0.086	0.931
Cassidy et al. (2011)	0.154	0.233	0.054	-0.302	0.610	0.662	0.508
Moss et al. (2011)	0.903	0.305	0.093	0.306	1.500	2.963	0.003
Bernard et al. (2012)	0.717	0.218	0.048	0.289	1.144	3.286	0.001
	0.365	0.175	0.031	0.023	0.708	2.091	0.037

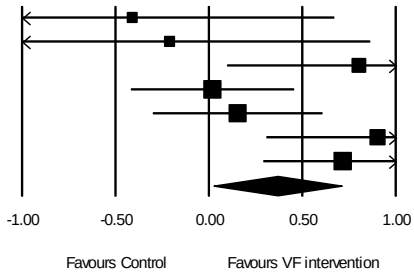

Figure 6: Post-treatment comparative efficacy for infant attachment disorganisation

This effect size would need more than 11 studies (fail-safe N) with null results to reduce the effect to non-significance - falling below the proposed criterion for robustness (5k + 10 = 45). Therefore, results should be interpreted with caution. Again, the 'trim-and-fill' approach was used to assess for publication bias, and no studies needed to be trimmed and filled (see Figure 7).

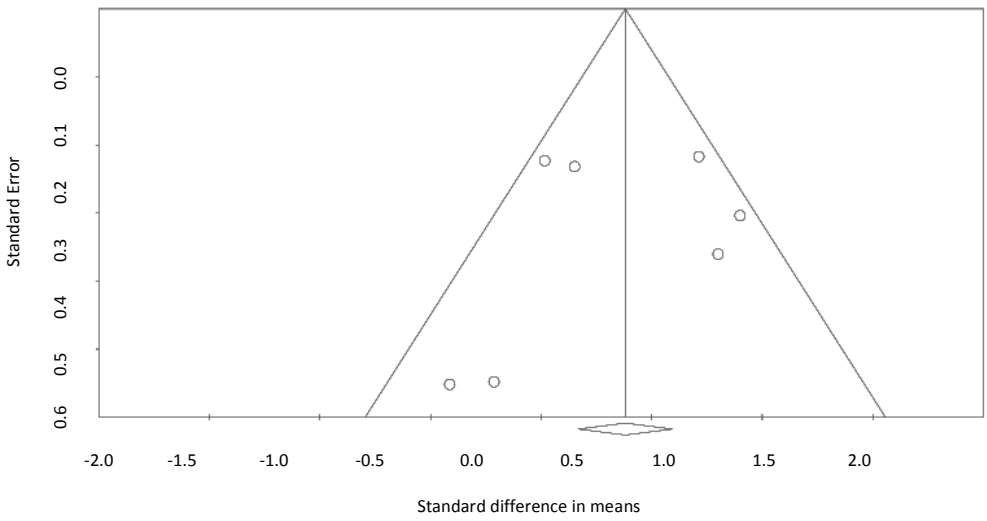

Figure 7. Funnel Plot to Assess Publication Bias for Infant Attachment Disorganisation

The interventions demonstrated diverging outcomes on infant attachment disorganisation. Two studies reported negative effects, whilst the remaining interventions established positive effects. However, the size of these effects ranged considerably. It appears that the most effective studies (and the only ones which produced significant effects) were those which delivered interventions to infants who were specifically at elevated risk of developing disorganised attachments, such as those who had previously been maltreated (Bernard et al., 2012, d = 0.72; Moss et al., d = 0.90) or who had been adopted (Juffer et al., 2005, d = 0.80), in comparison to those which delivered interventions to other high-risk groups such as low SES adolescent mothers (Moran et al., 2005, d = 0.02), highly irritable infants (Cassidy et al., 2011, d = 0.15) or insecurely attached mothers (Bakermans-Kranenburg et al., 1998, study 1, d = -0.41; Bakermans-Kranenburg et al., 1998, study 2, d = -0.21). Similarly, two of the most effective interventions (Bernard et al., 2012; Moss et al., 2011) were designed to specifically target disorganisation through attempting to reduce parental frightened and frightening behaviour alongside targeting parental sensitivity. Moderator analyses are not recommended when the number of interventions in one of the subsets falls below 4, however, in order to examine these observed differences further, comparisons between the two groups were made. Due to the small number of included studies results should be interpreted with caution. The contrast between interventions which were delivered to children who had previously been maltreated or adopted (d = 0.784, $p < .001$) and those delivered to lower risk samples (d = 0.27, p = .86) was significant (Q = 12.07, $p < .001$), suggesting that interventions which target infants at elevated risk of disorganisation are significantly more effective at preventing disorganisation.

Discussion

The current review provides meta-analytic evidence for the efficacy of video-feedback interventions at promoting parental sensitivity and preventing infant attachment insecurity and disorganisation. Drawing on data from 17 studies involving 1,368 children, a significant combined effect of d = 0.41 was found for sensitivity, suggesting that video-feedback interventions are effective at enhancing parental sensitivity. This effect is robust, requiring over 231 studies with null results to reduce it to non-significance. The interpretation of the size of combined effects is a controversial issue. McCartney & Rosenthal (2000) note that no absolute criteria for the evaluation of effect sizes exists, suggesting that applying such criteria arbitrarily may result in small effect sizes being dismissed as trivial, despite having considerable practical and theoretical importance. Instead, they suggest it is more meaningful to consider the size of the effect in context. In that respect, for comparison, Furlong et al. (2012) report meta-analytical data examining the effectiveness of behavioural and cognitive-behavioural parenting programmes (e.g. The Incredible Years Training Series, Webster-Stratton, 2000) for children with conduct problems; and report an effect size of d = -0.42 with regards to reductions in negative or harsh parental behaviours based on independent assessment. In addition, the magnitude of the current review's combined effect is similar, although slightly smaller, than the effect found in the Fukkink (2008) meta-analysis on the efficacy of video-feedback interventions on parental behaviour (d = 0.47). However, the current meta-analysis provides a more precise estimate of the effect on parental sensitivity specifically, rather than on a combination of various other positive parental behaviours. Moreover, this finding is consistent with evidence from the Bakermans-Kranenburg et al. (2003) meta-analysis which reported an effect size of d = 0.44 for a subset of randomised sensitivity interventions which utilised video-

feedback techniques. The current results therefore provide further evidence for the effectiveness of video-feedback techniques in promoting parental sensitivity.

We hypothesise that the very nature of video-feedback techniques makes them effective at promoting sensitivity. Ainsworth's definition of parental sensitivity specifies that parents must first accurately perceive and interpret their infant's signals, and to secondly respond to those signals in an appropriate manner. The use of video-feedback techniques is well suited to developing parents' abilities to achieve both of these tasks. Firstly, with regards to the accurate perception and interpretation of infant's signals, the use of multiple video clips of real-life interactions between parents and their infants allows the intervener to clearly draw the parent's attention to specific instances of infant behaviour. This then allows interveners to explore parent's interpretations of those behaviours and provide coaching in order to enable them to understand the behaviour in a more accurate way. Video-feedback allows interactions to be slowed down and examined in depth, providing both additional time for reflection, and also an opportunity to highlight and contemplate the vast number of signals and communications that occur in a very short interaction, which may otherwise be missed. Over time, this is likely to improve parents' ability to consistently notice their infants' signals. Secondly, parents must be able to respond appropriately. As suggested by Juffer et al. (2005), by repeatedly showing video-clips of parent's sensitive behaviour the intervener is able to reinforce and encourage appropriate and prompt responding to the infant's signals, thus making them more likely to re-occur. By virtue of the very nature of video-feedback, the process is likely to be extremely relevant to parents; they are likely to pay more attention and be more emotionally involved when watching interactions between themselves and their own child, compared to watching video-

clips of other dyads. It also provides explicit and concrete examples of the behaviours under discussion.

Video-feedback interventions are relatively brief (those included in this review range from 1 to 13 sessions) and are easy to manualise. They also may be more straightforward to implement and require less extensive training for interveners in comparison to more psychotherapeutic programmes. Given the significant improvements demonstrated, this makes them a cost effective option.

The second set of meta-analyses included 12 studies reporting intervention effects on infant attachment security, involving 934 families. A significant combined effect size of d = 0.25 was found. The robustness of this effect is questionable, as it would only require 22 studies with null results to reduce it to non-significance, thus failing Rosenthal's criteria (Rosenthal, 1979). To put this effect size in context, previous meta-analyses have demonstrated an effect size of d = -0.44 with regards to improving child behaviour (e.g. reducing conduct problems) following behavioural/cognitive behavioural parenting interventions (Furlong et al., 2012), and Bakermans-Kranenburg et al. (2003) reported an effect size of d = 0.20 with regards to promoting infant attachment security. It is interesting to note that Bakermans-Kranenburg et al.'s (2003) meta-analysis concluded that randomised attachment interventions which didn't utilise video-feedback techniques were significantly more effective at promoting infant attachment security (d = 0.25, $p < 0.01$) than those that did contain video-feedback, and indeed that the latter were not effective at all (d = 0.07, ns). The current review's findings contradict this result, suggesting that video-feedback interventions may be effective at enhancing attachment security as well as parental sensitivity. This discrepancy in findings may be due to the number of larger RCTs that have been conducted since 2003, which provide important evidence for the efficacy of video-

feedback interventions and promoting secure attachments in infants. Since the current review has demonstrated that video-feedback interventions are effective at enhancing parental sensitivity, an established determinant of attachment security, it is encouraging that the same interventions are also having a positive impact on infant attachment security, indicating that these interventions may be having the dual level effect predicted by theory: promoting changes in parental behaviour and in so doing promoting the development of secure attachments in their children.

The current study also examined the role of potentially important moderators of the efficacy of video-feedback interventions on infant attachment security and parental sensitivity. However, most likely due to the relatively small number of included studies, no significant moderators were identified, and numerous contrasts could not be tested due to the low number of studies in each comparison. Several investigated moderators approached significance, indicating a tendency for video-feedback interventions to be more effective at promoting both parental sensitivity and infant attachment security with samples considered to be low-medium SES rather than medium-high SES, which is line with findings from previous meta-analyses (Bakerman-Kranenburg et al., 2003). Similarly, although not quite reaching significance, results suggested that the effects of video-feedback interventions on parental sensitivity might be moderated by program duration, rather than number of sessions. This is related to Bakermans-Kranenburg et al.'s (2003) "less is more" hypothesis, although suggests that intensive (i.e. those where sessions are delivered across fewer weeks) rather than brief interventions (i.e. those with fewer sessions) are more effective. This finding is also consistent with other previous meta-analyses that suggested "short but powerful" interventions are most effective (Fukkink, 2008).

The final set of meta-analyses included seven studies reporting intervention effects on infant attachment disorganisation, involving 608 families. A significant combined effect of d = 0.37 was found, suggesting that video-feedback interventions are moderately effective at preventing infant attachment disorganisation. This is an exciting finding given that a previous meta-analysis investigating the effectiveness of preventative (although not specifically video-feedback) interventions on infant attachment disorganisation found no significant treatment effect (d = 0.05; Bakermans-Kranenburg et al., 2005).

There are well-documented negative effects of infant attachment disorganisation; therefore, discovering whether early parenting interventions are effective in preventing or changing attachment disorganisation is of great clinical relevance. The results from the current review are an important first step, providing meta-analytical evidence for the effectiveness of video-feedback interventions in preventing disorganisation. However, the current review's finding is based on limited data, as there is a paucity of studies reporting disorganisation as an outcome. Therefore, further research is required in order to address this question more systematically. Additional research will enable examination of the characteristics of interventions and samples that are associated with the biggest effects, and therefore allow interventions to be further developed and refined in order to maximise effectiveness.

Despite the consistent finding that infant attachment disorganisation is associated with later psychopathology and maladaptive social behaviours, there are relatively few theoretically driven interventions which target infant disorganisation. Bakerman-Kranenburg et al., (2005) noted that none of the studies included in their meta-analysis designed interventions that exclusively aimed to prevent disorganisation

or focused on the reduction of frightening or frightened parental behaviours, and only two of the interventions included in the current review tailored interventions in such a way (Bernard et al., 2012; Moss et al., 2011). The results of the current review indicate that effect sizes for interventions which include disorganisation as an outcome appear to cluster in two groups. Interventions with the largest (and significant) effect sizes (d ranging between 0.72 – 0.90) tended to be those which delivered interventions to infants who were specifically at elevated risk of developing disorganised attachments due to early experiences of adversity such as experiencing maltreatment or parental separation (Bernard et al., 2012; Juffer et al., 2005; Moss et al., 2011). This group also included the only two interventions specifically designed to target infant attachment disorganisation through attempting to reduce parental frightened and frightening behaviour alongside increasing parental sensitivity (Bernard et al., 2012; Moss et al., 2011). In comparison, interventions which did not target groups who were at specific risk for disorganisation appeared to have much smaller (and non-significant) effects (d ranging between -0.41 – 0.15). Moderator analysis indicated that the difference between these two groups was significant, suggesting that interventions which target infants at elevated risk of disorganisation are significantly more effective at preventing disorganisation. However, due to the small number of included studies in this contrast, the conclusions drawn are tentative. Additional intervention studies examining the effectiveness of interventions which target infant attachment disorganisation specifically are urgently required.

Bakerman-Kranenburg et al., (2005) concluded that interventions which were more successful at preventing disorganisation tended to be delivered to samples with high-risk children (e.g. adopted infants, highly irritable infants, premature infants), rather than high-risk parents (e.g. impoverished, socially isolated, insecure attachment

classification). Similarly, Bakerman-Kranenburg et al., (2003) found that interventions delivered to samples with higher proportions of insecurely attached infants were associated with significantly larger effect sizes. It may be that attachment interventions are more effective when targeted at infants who are at higher risk of attachment-related problems (e.g. developing either insecure or disorganised attachments). Alternatively, higher proportions of either insecure or disorganised attachments in the sample may mean that it is easier for the intervention group to outperform the control group, preventing a ceiling effect from diminishing the interventions' effectiveness.

There are several possible explanations for the demonstrated effectiveness of these interventions at preventing disorganisation. Firstly, some of the most effective interventions incorporated strategies to target established determinants of disorganised attachment (Hesse & Main, 2006; Van IJzendoorn et al., 1999). These interventions aimed to promote not only parental sensitive behaviour (associated with infant attachment security), but to also reduce parent's frightening, extremely intrusive, or unresponsive behaviours. Further research is required in order to examine whether or not changes in parental frightening behaviour mediate the effect on infant attachment disorganisation. Similarly, sensitivity-only focused interventions might have also been successful in affecting aspects of parenting that are important for disorganised attachment. Lyons-Ruth and Jacobvitz (1999) suggest that disorganisation might occur not just as a result of parental frightened or frightening behaviour, but also from extremely insensitive or neglectful parenting. In support of this, meta-analytic data demonstrated a small, but significant effect size ($r = 0.10$) between parental insensitivity and disorganisation (Van IJzendoorn et al., 1999). Moreover, Lyons-Ruth & Jacobvitz (1999) suggest that specific types of insensitive parental behaviour may be linked to disorganisation in a much stronger way than others. For example, parental

intrusiveness and interfering, disruptive behaviour, and parental frightened or withdrawn behaviour may be experienced as frightening by the infant leading to the development of disorganised attachment. Interventions which targeted these particular insensitive parental behaviours may have been more successful in preventing disorganisation. Further research is needed to identify whether particular types of insensitive parental behaviours are associated with frightening parental behaviour and disorganisation in infants. The results of the current review also indicate that interventions which target infants at elevated risk for developing disorganised attachment may be more effective than those that target other populations. More research is firstly needed to investigate the robustness of this finding, and, if necessary, to then examine what works for populations at low-medium risk of developing disorganised attachments.

Summary and Future Directions

The current review provides evidence that video-feedback interventions are efficacious in promoting parental sensitivity and improving infant attachment security and organisation. The current results provide empirical support that parental sensitivity is causally implicated in attachment security, as interventions which target parental sensitivity are effective at enhancing infant attachment security and organisation. These findings suggest that video-feedback interventions may offer exciting potential for clinical practice; they are brief and relatively low cost to implement, and given the significant improvements demonstrated this makes them very attractive clinically and to commissioners of health and social care services.

Only one significant moderator of intervention efficacy was found in the current review. There is a need for further research into characteristics which moderate

treatment effect in order to identify specific aspects of early interventions that are critical to their effectiveness, alongside examining links between effectiveness and sample characteristics and the complex interaction between these characteristics. This will allow interventions to be further refined, and will allow examination of 'what works for whom'. Dismantling studies will also assess the relative contribution of video-feedback components in interventions. In addition, long-term outcome studies are needed to assess whether improving infant attachment security and preventing disorganisation have long-term meaningful outcomes for children. This will require substantially powered studies, as the effects on such outcomes over time are likely to be modest.

The current review's finding that sensitivity-focussed video-feedback interventions can change or prevent infant attachment disorganisation is of great clinical importance. Further intervention studies are required to address the important question of whether interventions which specifically target known correlates of disorganised attachment, such as parental frightening or frightened behaviour, can prevent infant attachment disorganisation. This will require new interventions to be developed that specifically aim to reduce disorganisation. Since infant disorganisation is associated with elevated risk for psychopathology, it is of great clinical importance to design, evidence and refine such interventions.

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Part 2: Empirical Paper

Minding the Baby: The challenges of implementing a reflective functioning programme with high-risk families

Abstract

Aims: Minding the Baby (MTB) is a mentalisation-based preventative parenting programme developed explicitly to promote secure parent-child attachment relationships through enhancing parental reflective functioning. The theoretical underpinnings of the model highlight that the relationship with practitioners is central to the development of parental reflective functioning. However, establishing meaningful and secure therapeutic alliances with young mothers whose own histories are characterised by attachment disruptions and trauma is challenging. This qualitative study explored practitioners' views on what facilitates and hinders building and maintaining these relationships, and the challenges faced when trying to translate reflective functioning theory into practice with high-risk families.

Methods: Thirteen semi-structured interviews were conducted with practitioners who delivered the MTB programme during the pilot phase of an RCT.

Results: Thematic analysis generated nine categories of themes, which were organised into two domains. The first domain relates to the challenges of implementation, whilst the second domain reflects the components of MTB which practitioners identified as being crucial in engaging mothers in a mentalisation-based intervention.

Conclusions: The findings point to the importance of the context in which reflective interventions are delivered, highlighting the need to design and deliver services which support mentalisation throughout multiple levels of systems. In addition, a strong therapeutic relationship is crucial in engaging mothers in reflective work and in responding to the challenges of implementing a mentalisation-based parenting intervention.

Introduction

Minding the Baby (MTB) is a mentalisation-based preventative parenting programme which incorporates nurse home-visiting and infant-parent psychotherapy models, developed explicitly to promote secure parent-child attachment relationships through engaging and enhancing parental reflective functioning. The programme is targeted at 'high-risk' families, where the mother is under 25 years old with additional and complex needs (e.g. homelessness, significant maternal pathology, history of maltreatment or neglect in the mother's childhood, or maternal experience of being looked after by a local authority). The tasks of early parenthood alongside such considerable additional complexities result in such families being at elevated risk for a wide range of negative outcomes. Not only are the effects of chronic poverty and social disadvantage on infant development far reaching – impacting health, emotional, relational, social and cognitive outcomes (Shonkoff & Phillips, 2000) - but the complexity of needs in these families are also likely to make it more difficult for them to access community parenting programmes. Therefore, interventions targeting high-need families must address their key vulnerabilities in order to engage and deliver a meaningful therapeutic intervention.

MTB is a relatively new programme, and research examining its efficacy is preliminary. The first wave of outcomes from a pilot-phase randomised controlled trial has demonstrated that MTB has positive effects on both health and attachment outcomes (Sadler et al., 2013). Although this initial evidence is promising with regards to the efficacy of MTB, less in known about how these positive outcomes are achieved. Understanding the components of the model that effect change and the processes involved in producing better outcomes, alongside understanding the challenges of implementation and difficulties with translating the theory into practice, is needed in

order to refine the model and enhance implementation so as to improve clinical practice.

Theoretical foundations

MTB is grounded in both social ecology and attachment theories, with a particular emphasis on reflective functioning. Attachment based early preventative interventions have been demonstrated to be effective in enhancing both parental sensitivity and infant attachment security (Bakerman-kranenburg, Van IJzendoorn & Juffer, 2003). However, Slade (2006) argues that the success of many of these interventions is actually the result of changes in parental reflective functioning that arise as a by-product of focussing on the parent-child relationship.

The construct of reflective functioning, first introduced by Fonagy and colleagues (Fonagy et al., 1995), emerged from the literature on attachment theory. It is closely linked to the concept of mentalisation, and refers to a person's ability to not only envisage mental states (such as thoughts, feelings, beliefs, intentions, desires) in the self and others, but to also interpret behaviour as meaningful on the basis of such mental states. Thus, maternal reflective functioning refers to the ability of the mother to accurately recognise mental states in herself and her child (including the ability to accurately distinguish between the two), and to appreciate the dynamic relationship between mental states and behaviour in a meaningful and accurate way. Reflective functioning can be considered along a continuum (Fonagy et al., 2002; Slade, 2006), such that some parents will barely be able to recognise or tolerate mental states within themselves, whilst others will have the ability to describe such dynamic and interpersonal relationships between their own mental state, and the mental state of their child.

Fonagy et al. (1995) suggest that the mother's ability to 'hold' complex mental states in mind allows her to hold her child's internal affective experience in mind, and thus allows her to understand her child's behaviour as meaningful on the basis of their internal mental experience. By doing so (e.g. by representing the emotional experience back to the child in a regulated manner) the mother engenders the development of a sense of safety and security in the child.

Research has suggested that maternal reflective functioning is not only important for facilitating a range of developmental processes, but also that its absence is instrumental in the development of psychopathology. Fonagy et al. (2002) suggest the importance of maternal reflective functioning in promoting secure attachments (which has been found to predict a wide range of positive developmental, relational and social outcomes across infancy and childhood (Carlson & Sroufe, 1995)), asserting that both maternal sensitivity and secure attachment arise as a consequence of maternal reflective functioning. In support of this notion, researchers have demonstrated that the relationship between adult attachment and parental reflective functioning is significant, as is the relationship between parental reflective functioning and child attachment organisation (Slade, Grienenberger, Bernbach, Levy & Locker, 2005), concluding that maternal reflective functioning plays a crucial role in the intergenerational transmission of attachment.

Furthermore, maternal reflective functioning has been demonstrated to be negatively associated with infant attachment disorganisation (Kelly, Slade & Grienenberger, 2005), which has consistently been identified as a significant risk factor for later psychopathology (Lyons-Ruth & Jacobvitz, 2008; Moss, Cyr, Bureau, Tarabulsy, & Dubois-Comtois, 2005). Theories attempting to explain the development of infant attachment disorganisation identify the causal role of parental 'frightened or

frightening' behaviour (Main & Hesse, 1990). Low maternal reflective functioning and a mother's difficulty to attune to her infant's experience may underlie her capacity to frighten or be frightened by her child (Lyons-Ruth, Bronfman, & Attwood, 1999; Main & Hesse, 1990). In addition, parental reflective functioning has also been theoretically linked with capacity for affect regulation and relatedness (Slade et al., 2005). Since parental reflective functioning is fundamental in promoting children's ability to mentalise and understand their own social environment, it is crucial for their ability to develop and sustain meaningful relationships.

Implementing Minding the Baby

MTB aims to help parents to 'keep their child in mind' in increasingly complex ways by engaging and enhancing reflective functioning through a variety of strategies (Sadler, Slade & Mayer, 2006). The programme is primarily delivered to mothers, although fathers and other family members are sometimes included. There is significant variation in mothers' ability to reflect on their own and their infants' mental experience; therefore practitioners must first evaluate mothers' reflective capacity and identify barriers and factors that impede their ability to consider their own and their infants' mental states. Parents can then be encouraged to move through the stages of reflective functioning, which, as outlined by Slade (2006), range from helping parents to contemplate very basic mental states to assisting them to contemplate the interpersonal and dynamic relationship between one person's internal experience and another's. This therapeutic task is achieved through "modelling reflectiveness" and "facilitating wondering", where practitioners constantly represent the child to the parent in terms of mental states, and encourage parental curiosity about their child's inner experience.

It is likely that the reflective functioning capacities in the high-risk group of parents targeted by MTB are particularly underdeveloped, partly as a function of their own complex and traumatic life experiences; for mothers with a history of complex trauma, contemplating their own mind or the mind of another can be a threatening and challenging task (Slade, 2006). Furthermore, the experience of complex trauma is likely to disrupt mothers' ability to parent as well as their ability to engage in treatment. Slade (2006) suggests that these parents may struggle in areas where they themselves have not had the experience of being cared for, or understood. For these parents, it is necessary for the practitioner to be able to hold the parent in mind, in both concrete and abstract ways, so that they are able to understand their own mental states and regulate their own distress, before they are able to begin to consider the mental states of their child. It is therefore evident that the therapeutic relationship is very important in the emergence and development of parental reflective functioning capacities. However, establishing such alliances with young mothers whose own histories are characterised by attachment disruptions and trauma is likely to be challenging. In addition, the task of early parenthood alongside additional complexity often observed in this client group such as homelessness, extreme deprivation and domestic violence, results in practitioners being repeatedly faced with crises and demands, and means that consistency (e.g. maintaining regularly schedules appointments) within the therapy is difficult to achieve (Slade et al., 2005). As a result, such levels of deprivation, crises and chaos are likely to threaten the clinician's ability to keep the baby, and mother, in mind. The supervisory model employed within the MTB programme therefore becomes crucial in managing these complexities.

Supervision

The tasks of effective supervision are many and complex, with different approaches to supervision privileging different processes, tasks and functions. Those involved with developing the MTB programme describe the tasks of supervision as being to "set priorities, identify barriers, and explore alternative routes to enhance reflective capacities while addressing the concrete and physical needs of the family" (Slade et al., 2005, p. 84). In keeping with the interdisciplinary approach adopted within the MTB model, multiple theoretical models of supervision are utilised and integrated, so that practitioners receive different layers of input. However, the core model of supervision delivered to practitioners is reflective, both at a group and individual level. Reflective supervision is a model of supervision that is well established in the infant-family field in the US. The focus of this model is "the shared exploration of the emotional content of infant and family work as expressed in relationships between parents and infants, parents and practitioners, and supervisors and practitioners" (Weatherston & Barron, 2009, p. 63). The nature of working intensively with high-risk families is likely to expose practitioners to distressing content and situations, which are likely to provoke high emotion, which in turn is likely to have an effect on practice. One of the aims of reflective supervision is to provide a space for the exploration of how the content of the work affects practitioners, and how their emotional reactions in turn affect the way that they work. The exploration of often highly emotional content, understandably, calls for a secure and trusting relationship between supervisor and supervisee. The second distinguishing feature of reflective supervision is the exploration of the parallel process. That is, attention to all of the relationships is important, including those between the supervisor and supervisee, between the practitioner and parent, and between the parent and the infant; the assumption is that

it is critical to understand how each of these relationships affects the others (Weatherston, Weigand & Weigand, 2010).

Rationale and aims of the present study

The theoretical underpinnings of the MTB model highlight that the relationship with practitioners is central to the emergence and development of parental reflective functioning. However, forming such a therapeutic relationship with high-risk families might be particularly challenging due to the difficulties these families present with. It is therefore crucial to understand what facilitates and hinders building these relationships, and the challenges faced when trying to implement a reflective functioning programme with high-risk families. Although preliminary research has indicated the efficacy of MTB in producing a range of positive health and attachment outcomes, little is known about how these outcomes are achieved. Similarly, there is an absence of research examining the challenges of implementing the model and difficulties of translating the theory into practice. Such research is essential, especially as MTB is a relatively new programme, to enable refinement of the model, ensuring the effectiveness of the intervention is maximised.

The current study used a qualitative approach to explore the challenges of implementing the MTB model. Qualitative methods are well suited to gaining a more detailed and comprehensive understanding of a phenomenon, going beyond the simplifications often made by quantitative methods. Qualitative approaches are particularly useful in capturing the complexity, variety and richness of respondents' experiences, and of gaining a "thick description" (Geertz, 1973), which is particularly helpful when aiming to gain detailed understandings of the complex psychological and interpersonal processes that underlie therapeutic interventions (Elliott, 2010; McLeod,

2011; Pistrang & Barker, 2010). Furthermore, qualitative methods are more able to identify new and unexpected ideas that might otherwise go unexamined in hypothetico-deductive models of research, which often utilise standardised measures to assess predetermined areas of inquiry.

The current qualitative study focused on the challenges of translating theory into practice within the MTB model, from the perspective of the practitioners delivering the programme. Specifically, the study aimed to explore the following questions:

1. What promotes and hinders the engagement of high-risk families into the MTB model, and what are the challenges to sustaining this engagement?

2. What are the challenges of implementing the MTB model and applying reflective functioning theory in practice, and what facilitates the programme's implementation?

Method

The current study was part of the pilot phase of a wider multi-site randomised controlled trial evaluating the effectiveness of the Minding the Baby (MTB) programme in preventing a range of negative maternal and infant outcomes. MTB was delivered by the National Society for the Prevention of Cruelty to Children (NSPCC) across three sites in the UK. The current study was conducted in collaboration with another UCL Clinical Psychology doctoral student, whose thesis examines parents' experiences of the therapeutic process in MTB (Burns, 2014). Appendix 1 provides a summary of the joint work conducted.

Ethical approval

Ethical approval for this research was obtained from the ethics committees at University College London and the NSPCC (see Appendix 2).

MTB Programme

The MTB programme was delivered to each family by two practitioners: a clinical social worker and a nurse practitioner. Each practitioner had a distinctive focus, although there was considerable overlap between the two roles. The key task of each discipline was to promote reflective functioning and to support the mother's capacity to keep the baby in mind. In addition, the nurse practitioner's role centred around health and development, whilst the clinical social worker's focus was on mental health and wider family and systems issues. Although MTB is a manualised approach with established protocols and guidelines specified in a treatment manual (Slade et al., 2010), it is administered in a highly individualised way on the basis of the needs of each family and circumstances present during each home visit. Each family is seen on a weekly basis, alternating between clinical social worker and nurse home visits, from three months prior to the child's birth until the child's first birthday. After this time the family is seen every other week until the child reaches two years of age. Home visits last approximately one hour, although this often varies considerably depending on the family's needs.

Supervision is delivered in a multifaceted way within the MTB programme. In the current study, the majority of supervision was delivered locally, by professionals from a leading school for nursing and from a leading institute specialising in infant-parent mental health, with a combination of individual, group and joint (for each staff dyad) sessions. Supervision was delivered jointly to ensure that each staff dyad had the

opportunity to share perspectives on the families they were working with. In addition to local supervision, practitioners also received consultation and supervision from the researchers who developed the MTB programme at Yale, which was conducted via Skype. In total, each practitioner received approximately 2 hours of individual local supervision, 1.5 hours local group supervision and 1 hour of consultation/supervision via Skype each week. Furthermore, every month each staff dyad received additional joint supervision from the team at Yale.

Participants

All practitioners who were delivering MTB across the three UK sites were invited to take part in the study. There was the equivalent of four full time practitioners in each site. In several of the sites there were a number of part time staff, resulting in a total of 18 members of staff altogether. Four practitioners left their posts before being invited to participate in the research. Therefore a total of 14 practitioners were invited, all of whom subsequently agreed to participate. One practitioner was not able to attend the scheduled interview due to a crisis with one of her families, resulting in a total of 13 practitioners interviewed.

All participants were White British and female, with a mean age of 44 years (range 28 -58). On average, practitioners had been delivering MTB for 16 months (range 12 - 24) at the time of their interview. Clinical social workers held a variety of social work and/or therapeutic qualifications (such as play therapy or counselling), and had been qualified for 13 years on average (range 5 - 25 years). Nurse practitioners were all Registered General Nurses (RGN) or Registered Nurse Child (RNC), and had been qualified for 16.6 years on average (range 8 – 25 years). The majority of the nurses also

held additional post-graduate qualifications or were also qualified as Nurse Prescribers or in Specialist Practitioner Public Health Nursing (Health Visitor).

Procedure

MTB is delivered three months prior to the child's birth and continues until the infant is two years old. In order to capture the challenges of implementing the model with mothers as they navigate the different developmental tasks across this age range, as well as capturing the challenges of delivering the programme at different intensities (e.g. weekly compared to fortnightly visits) and whilst undertaking different therapeutic tasks (e.g. engagement through to endings), practitioners were assigned to one of three interview phases. Practitioners who had the most new cases (e.g. from enrolment in MTB until the birth of the child) were interviewed first, within the "engagement phase" of interviews (n = 4). This was to ensure the challenges of engaging families were captured whist still fresh in Practitioner's minds. Practitioners who had the most cases involving older infants (e.g. when the child was between one and two years old) were interviewed last, in the "ending phase" of interviews (n =5). This was to maximise the number of cases that were approaching the end of the intervention to ensure that the challenges of this task were adequately captured. All other practitioners were seen in the "middle phase" of interviews (n = 4). Practitioners were ascribed to one of these three phases on the basis of their caseload. The researcher was provided with a list detailing the number of families each practitioner was working with, and the age of the child in each family. On the basis of this information, practitioners were assigned to either the engagement phase, the middle phase or the ending phase of interviews.

Practitioners were sent an email containing information about the project, and were invited to contact the researcher should they wish to participate. An information

sheet (Appendix 3) was also attached to this email. Once interest to participate was expressed by a practitioner, a brief telephone conversation or email exchange took place in order to provide further information and to arrange a time to conduct the research interview. All interviews were conducted at NSPCC offices. During the interview meeting, practitioners were given an additional copy of the information sheet to read and time was allocated for answering questions about the research. Practitioners were then asked to complete a consent form (Appendix 4). Participants were assured that the research team was independent to their employers (the NSPCC), and that the NSPCC would not have access to any of the interview recordings or transcripts. Furthermore, participants were informed that if they were worried that the information they provided would make it possible for others to identify them, they could request for sections of the interview to be excluded from the analysis.

Focus Group

A focus group was held in order to gain an overview of the challenges of implementing the programme. This information was subsequently used to develop the interview schedule. Data collected during the focus group was also used to inform the thematic analysis. All practitioners and managers were invited to attend to discuss the challenges faced when implementing the MTB programme. An interview guide was not developed for the focus group; instead an open and flexible approach was adopted, ensuring that practitioners and managers led the content of discussion. Firstly, it was explained to participants that the aim of the focus group was to get a broad overview of some of the challenges encountered when delivering MTB. The group was then invited to engage in a discussion on this topic. Three members of the research team acted as facilitators and asked for further clarification on points made, attempted to gauge the

level of agreement between practitioners, and tried to elicit the views of all members of the group. The focus group comprised 16 practitioners and 4 managers, and lasted for 1.5 hours. It was conducted during a development and training day at NSPCC offices prior to any research interviews taking place.

Interviews

A semi-structure interview schedule was developed specifically for this study based on established guidelines (Smith, 1995) to elicit detailed accounts of practitioners' experiences of implementing the model (Appendix 5). The aims of the research were delineated and broken down into several topics; draft questions were then composed in collaboration with senior researchers in the research team. This initial interview schedule was discussed and further refined during the focus group with MTB practitioners, where additional relevant topics and questions were also discussed and added. In order to tailor each interview to ensure that enough time was given to exploring all relevant topics, the interview began with a request for a brief overview of the practitioner's experience of delivering MTB, including a summary of the highs and lows and the challenges and successes they had encountered. Following this, there were four broad areas of questions concerned with practitioners' experiences of (1) engaging families, (2) maintaining relationships with families, (3) applying reflective functioning theory in practice, and (4) supervision. The order in which these areas were explored was led by the material the practitioner brought, and was also partially dependant on the phase of interview. Practitioners were encouraged to elaborate and give specific examples throughout, and to situate any challenges they identified in the context in which they occurred. Interviews lasted for approximately two hours (ranging from 1.5 hours to 3 hours) and were audio-recorded. Practitioners were invited to

contact the researcher after the interview had been completed if they realised there were additional relevant topics that had not been discussed.

The interview schedule was employed flexibly to ensure all relevant and meaningful information given by practitioners could be adequately explored in the interview in a manner that felt natural and coherent rather than prescriptive and disjointed. The interview schedule for each of the three interview phases did not vary in content, but did vary in the focus and the amount of time dedicated to eliciting details about particular topics. For example, more time was dedicated to exploring the challenges of engaging families in the programme and the transition from working with families before and after the birth of the child in the engagement interview phase, whereas more time was spent examining practitioners' experiences of delivering the programme on a reduced contact basis and managing endings with families in the ending phase of interviews. Practitioners were also asked questions not specific to their assigned interview phase; this was because all of the practitioners had varied caseloads, and were likely to have experienced challenges pertinent to each phase of therapy, irrespective of the interview phase they had been assigned to.

Qualitative analysis

Interviews were transcribed verbatim; the researcher transcribed four interviews (P1-4), whist the remaining 9 interviews were transcribed by a private transcription company (P5-13). Transcripts of the interviews were analysed thematically (Braun & Clarke, 2006). Thematic analysis is a flexible approach to qualitative analysis that aims to identify key ideas or patterns within the data: to describe complex data sets in terms of the central themes. This method is independent of any specific theoretical framework, and as such can be adapted to suit different approaches (e.g.

both realist/essentialist and constructionist paradigms). The approach was selected as it is appropriate to an inductive, exploratory study with a focus on subjective experience. Within this approach to qualitative analysis there are a number of distinct stages, which are cycled between in an iterative, rather than linear fashion, with the intention of identifying patterns or themes within the data, and then organising these themes in a way which accurately reflects the meaning evident in the data.

The first phase of analysis, “familiarisation”, involved reading each transcript and listening to a selection of the recordings in order to become immersed in the data. Key ideas and recurrent themes were then noted down. Following this, five transcripts were selected on the basis that they provided the richest and fullest accounts of experience of the challenges faced when delivering MTB. These transcripts were examined in detail, and key ideas were identified and noted in the margins. During the second phase of analysis, a summary list of the key ideas identified in each of the five transcripts was produced. These five summary sheets were then compared and contrasted, and similar ideas and topics of interest were grouped together into initial themes. Each of the five transcripts was then re-read to ensure these themes represented the raw data adequately, and to identify relevant data extracts which demonstrated each theme. Following this, the remaining eight transcripts were examined against these initial themes. Again, key ideas were noted in the margins, and the initial list of themes was edited, adjusted and added to accordingly. Data extracts for each theme were then collated across all interviews, using colour co-ordinated text to identify each participant. The next phase of analysis involved grouping these initial themes into potential domains in order to provide an organising thematic framework. Each transcript was then revisited a final time to ensure that the proposed themes and domains were evident in individual accounts, and to collate illustrative quotations to

provide evidence for each theme. This final examination of each transcript also allowed each theme to be further refined, and to ensure that relevant contradictions, nuances and exceptions were captured. An illustration of the main stages of analysis is presented in Appendix 6.

Credibility Checks

Drawing on published guidelines for good practice in qualitative research and criteria for assessing the credibility of qualitative research (Barker & Pistrang, 2005; Elliott Fischer & Rennie, 1999; Stiles 1993), several credibility checks were employed to enhance the quality and validity of the analysis and subsequent conclusions. A consensus approach was used during the analysis and development of the thematic framework; a selection of the data was examined by two additional members of the research team, who then came together to compare ideas and tentative themes, and through discussion reached a consensus as to the best way to represent the data. Similarly, in order to decide the best way of labelling and organising the themes, multiple discussions were had with the research supervisors, and a consensus approach was then adopted to agree the final thematic framework. In order to ensure that the themes were grounded in participants' accounts, illustrative excerpts were used to demonstrate the themes during each stage of analysis and in the final presentation of the results.

Researcher's perspective

Prior to conducting this research, I had no personal experience of delivering MTB and had never worked therapeutically within this theoretical model (i.e. mentalisation/reflective functioning based interventions). I had previously worked with parents from high-risk backgrounds in a social care setting which employed the Family

Partnership Model (Davis & Day, 2010). This approach explicitly emphasises the importance of developing partnerships with families, spending considerable efforts to explore parents' understanding and construction of their situation, and focussing on parents' strengths and facilitating families' resilience. Partly owing to this experience, I came to the current study with an awareness of how difficult it can be to engage parents with complex socio-emotional difficulties, in addition to beliefs about the importance of building collaborative, genuine and respectful partnerships with families. In addition, I had previously worked with children who were in care or who had experienced neglect and abuse, and their carers. Partly due to my training and theoretical understanding of attachment, it is likely that I came to the current study with preconceptions about the importance of early attachment experiences, in particular, working with looked after children led me to understand the sometimes devastating consequences of early experiences of neglect and abuse. This is likely to have led me to develop expectations about the importance of delivering early parenting interventions to high-risk families.

Results

The analysis generated nine categories of themes, grouped into two domains: "The challenges of translating theory into practice" and "The essential components" of the programme. The first domain concerns the barriers to the implementation of the model, whilst the second domain reflects the components of MTB which practitioners identified as being crucial in building relationships with mothers and engaging them in reflective work.

Domain 1: The Challenges of Translating Theory into Practice

When practitioners spoke about the challenges they faced when implementing this mentalisation-based model, it was clear that although some of the challenges lay in the immediate therapeutic context (e.g. involving the mother and the MTB practitioner), the wider context within which the reflective work took place was also extremely important. Challenges were identified at many different levels – from practitioners' relationship with mothers, to the complex relationships between organisations. Figure 1 illustrates the different systems in which challenges were identified, drawing upon Bronfenbrenner's (1979) ecological-systems model as an organising framework.

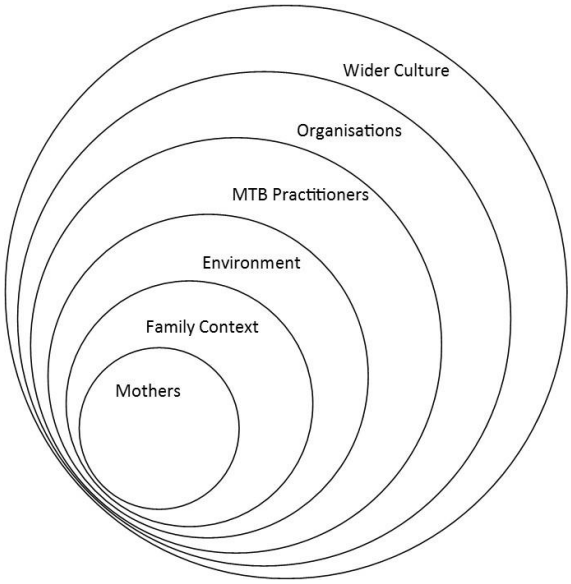

Figure 1. Ecological systems: categories of challenges when implementing MTB

Factors at each level came together and interacted to create challenges unique to each family. The importance of identifying and understanding the barriers to engagement for each mother, given her individual circumstances and presentation, was highlighted to be essential when trying to formulate how to intervene. Table 1 summarises the categories and themes in this domain. Table 2 provides illustrative quotations for each category.

Table 1.

Categories and themes in Domain 1: The challenges of translating theory into practice

Category	**Themes and sub-themes**
1.1 Mothers	1.1.1 Mothers' own unique history brings challenges
	Previous relationship history: trauma, neglect and abuse
	Mothers' attachment style
	Previous experience of professionals
	1.1.2 Mothers' motivations for engaging in Minding the Baby
	1.1.3 Minding the Baby is not for everyone
1.2 Family Context	1.2.1 Grandmothers
	1.2.2 Fathers
1.3 The Environment	1.3.1 The physical environment
	1.3.2 Crises and chaos
1.4 MTB Practitioners	1.4.1 Anxiety about getting reflective functioning right
	1.4.2 Emotional impact of the work
	1.4.3 Vague boundaries of the role
1.5 Organisational Level	1.5.1 Internal systems and requirements can shut down reflection
	Internal reporting systems
	Supervision
	Technology and resources
	1.5.2 Social Care involvement
	Shuts down mothers' ability to be open and to reflect
	Challenges the voluntary nature of the programme
	Raises "ethical" concerns for practitioners
1.6 Wider Culture	1.6.1 Common attitudes
	1.6.2 Cultural perception of agencies

Table 2.

Illustrative quotations for the categories in Domain 1.

Categories, themes and illustrative quotations
1.1. Mothers
1.1.1 Mothers' own unique history brings challenges
"We've had a few girls who have grown up in care, who have had all sorts of abuses happen and they don't have family support…a number of them, I think, have been so traumatised and so damaged that they're not…able to think about things...They're just not there and they're so hurt and so defended that to even open up that little space would be so painful for them that they're just not able to" [P7]
1.1.2 Mothers' motivations for engaging in MTB
"They have to have a certain level of motivation to want to do MTB…it's absolutely crucial…because unless we have that sort of sign-up then we're not working well with these girls…It's a struggle to get into doing the work with them when they weren't committed in the first place, there's no opening in terms of doing any work with them" [P10]
1.1.3 MTB is not for everyone
"I don't think the girls are able to do it (RF), the majority of them just can't. I think there are a lot of girls who are really, really traumatised from their own past…a lot of them have been in the care system and they've had all sorts of abuse in their backgrounds and they just don't know how to talk about it or to think about it, and they close down any conversation…I suppose my feelings are that it doesn't work with your very traumatised mums…who just don't seem to be able to open any semblance of that little way in" [P7]
1.2. Family Context
1.2.1 Grandmothers
"I think that some of the girls that we've had and we've lost it's been down to their mothers (the grandmothers)… [if you think about] the backgrounds of these young girls, and [then think of] their mothers' experiences…because they had their children young, and it hasn't been great... and then when we come in they see us…They put us in there. It's, like, ghosts in the nursery, you know. They see their experiences again and they think that's what's going to happen" [P13]
1.2.2 Fathers
"Certainly here in this city, dads are co-parenting [and] doing all the same tasks as mums in terms of baby care which brings potentially some risk issues if there are risk issues around dads. But also brings, you know, some real strengths and benefits and can blend some of the difficulties that mums may have because they bring another dynamic" [P5]
1.3. The Environment
1.3.1 The physical environment
"Recognising that the Mums need to be in a certain state of mind before they can be reflective…if they're sitting worrying because they don't have any heating, and they are cold…to try then to engage them into a meaningful discussion to develop some mentalisation isn't going to work" [P7]
1.3.2 Crises and chaos
"I think if people are in crisis, particularly around housing, it's very difficult to do this work. You could say that is the work, but if people are in such an anxious state about housing, about money…I wonder if they can do the depth of work that's needed because…those things are basics aren't they really? And maybe we're wanting them to go much deeper around

thinking about their baby, you know, the basics being in place that they have got a roof over their head, and I think the other basics about food and money is pretty significant, or heating. If our work is about helping the relationship, there's got to be room for it" [P11]

1.4. MTB Practitioners

1.4.1 Anxiety about getting reflective functioning right

"When I started the program, my anxiety was very high that I was going to get it right. I wanted to be the best possible, but worried I wasn't ever going to get it right." [P4]

1.4.2 Emotional impact of the work

"I've never had my head so full of people before, where you take them home with you. You can't switch off…you're really, just holding so much, horrible difficult information, and really feeling that for a lot of our girls that they haven't got anyone else really, we are their main source of support and the first place they turn to if they have problems, and that's really hard. That's hard to, it's just hard to have that responsibility sometimes, it's intense" [P1]

1.4.3 Vague boundaries of the role

"I feel I'm just never sure where my work ends. There are so many things that I can do that sometimes I feel absolutely quite scattered really, I mean, from re-homing a cat just, you know that was causing havoc, to taking somebody to housing…getting somebody some carpet…looking at furniture, trying to find some funding for them to get a washing machine, a fridge, freezer. Just the breadth of work is quite big really in practical ways..." [P11]

1.5. Organisational Level

1.5.1. Internal systems and requirements can shut down reflection

"[It] absolutely [has an impact on the way I work] and I don't even think it's subtle. I think that because I'm so conscious about what I need to write on my recording, I sometimes think within my sessions about how I'm going to record certain things rather than just enjoying the moment of being in the session and therefore losing probably some of the reflectiveness because I'm not probably as focused…I don't think it's subtle, I think it's like a brick, in some instances, that that recording is always in the back of your mind…" [P12]

1.5.2. Social Care involvement

"You're asking people to be open and sometimes they'll have some negative thoughts… sometimes they'll get really fed up with their baby…but how open can they be when they know that you are going to be going back to a case conference or core group and giving an update? It probably perpetuates a feeling that at any time a child could be removed, so how open can they be about sharing? They've got to have a distance emotionally in their relationship that they've got with the child. How reflective can they be if that's what they're having to do" [P6]

1.6 Wider Culture

1.6.1. Common attitudes

"And I think culturally, where we are, it's quite a harsh environment, where the general communication tends to be much more negative, people struggle to name anything positive about themselves or others. And that's very much [what it's like here], we don't tend to say positives. The terms of endearment are negative, and I don't know if that's the case across other parts of the UK, but it's certainly the case here. So here, where you're trying to feedback positives, even when the feelings are more hopeful and positive, they can still be portrayed as being more negative." [P3]

1.6.2. Cultural perception of agencies

"The perception, or the image could be that you get involved in cases that people talk about child cruelty. So the perception often can be that actually you're assuming they have the potential to be cruel to their child, rather than you coming from the assumption about they could be a good parent and you want to help them be a better parent" [P6]

1.1 Mothers

The mothers enrolled in MTB often presented with very complex needs and difficulties, which frequently created challenges when trying to engage them in reflective work. In particular, mothers' relationship and attachment histories and their motivations for engaging in the programme were highlighted as being important. In addition, cases where mothers had significant difficulties engaging in reflective work led practitioners to wonder whether MTB was suitable for everyone.

Theme 1.1.1 Mothers' own unique history brings challenges

Considerable emphasis was placed on each mother having her own unique history, which created a range of challenges when trying to implement MTB. Many practitioners spoke in terms of continuums, explaining that the mothers they were working with often fell at the extreme ends of various ranges, such as their level of "*avoidance"* or "*dependence"*, which all influenced their ability to trust others, form relationships and tolerate attention alongside impacting their capacity to reflect. Practitioners suggested that mothers' abilities in these areas were related to their experience of being in relationships with others in the past. Previous relationships with professionals, and mothers' attachment and relationship histories were highlighted as being particularly important.

By the very nature of the inclusion criteria for MTB, the majority of the mothers had previously experienced maltreatment whilst growing up. Practitioners described mothers as having "*horrible histories",* and detailed examples of severe neglect and abuse. With regards to the impact mothers' histories had on efforts to engage them and attempt to deliver any reflective work, practitioners explained that it often felt that mothers' heads were "*so full of their own history and experiences"* there was just "*no*

room" for anything else. Similarly, previous experiences of abusive or neglectful others resulted in mothers experiencing practitioners' attempts to form a relationship and be caring as "*intrusive"* and *"threatening".*

Moreover, practitioners discussed how mothers' attachment styles, in particular "*avoidant mums"* posed further challenges; these mothers found any direct attempts of reflection about their feelings intolerable and often withdrew or avoided any such conversations. Although working with "*avoidant mums"* was the predominant challenge discussed by practitioners, some also acknowledged that working with "*pre-occupied"* mothers brought new barriers; they often inundated practitioners with demands, and required so much support that it was often "*impossible*" to get to any reflective work.

Finally, many of the mothers enrolled in MTB had "*long histories*" of being involved with services. Practitioners explained that for these mothers, the common narrative about professionals was often a negative one. Furthermore, it was highlighted that mothers and their families (and often the wider community) shared a "*mistrust"* of professionals; practitioners explained that there was often a family story about professionals being "*untrustworthy", "interfering"* and *"out to steal your children".*

Theme 1.1.2. Mothers' motivations for engaging in MTB

Practitioners felt that a lot of variation in mothers' level of motivation to engage in MTB was evident, and that this impacted greatly on their ability to open up and form a relationship with them. They noticed a difference between the mothers who "*really wanted it"* and were committed to the full aims of the programme and had a desire to reflect, and those who had signed up for other reasons (e.g. pressure from social care, or a desire for practical support). It was highlighted that mothers really needed to be

committed to the programme and to want a "*better life for themselves and their babies*", reflecting that these were the mothers that "*really go for it*" and "*form a really good relationship*" with practitioners. However, it was also acknowledged that for some mothers, imagining something better was inconceivable due to their own histories and current circumstances, and that this made doing any reflective work very difficult. Practitioners recognised that for some families, they had 'sold' the programme as something that would provide practical help and promote child development, and did not explicitly discuss the level of therapeutic work or extent to which mothers' own histories and experiences would be explored, and wondered whether this had led to some families disengaging when exploration of their own experiences occurred as this was not what they had expected or signed up for.

Theme 1.1.3. MTB is not for everyone

Practitioners questioned whether MTB was suitable for all of the mothers they were working with. It was emphasised that there was considerable variation in mothers' level of ability to be reflective and to think about their own experience and the experience of their child. Practitioners felt that many of their mothers had notably low reflective functioning at the start of the programme, but explained that for a subset of mothers, their capacity was "*non-existent*". These mothers were described to have had "*so much trauma in their lives*" that they were either not able to tolerate any reflectiveness, or simply did not have the capacity to do so. Many practitioners felt that in these cases they had seen little improvement over the course of the intervention, and wondered if they were effecting any change - there was the sense that they were *"asking [mothers] to do the impossible".* Practitioners felt that these mothers were able to engage with many aspects of the practical and emotional support offered, but were

not able to access the central mentalisation component of the intervention, leading many of them to conclude that MTB might not be suitable. Not all practitioners shared this view, however; a few strongly advocated that "*the most traumatised [mothers] are the ones we should be working with*".

1.2 Family Context

Practitioners spoke in detail about how mothers were often very isolated, with very few sources of social support. A lot of the mothers enrolled in the programme did not have contact with their families, many of them having been taken into care as a child, and those who did have contact, often had difficult relationships due to their experiences growing up. It was noted that family relationships could have dramatically different impacts on the programme for different families. Two family relationships were spoken about in particular: grandmothers and fathers. Sometimes these relationships were identified as a great source of support, which acted to foster mothers' reflective capacities and enhance mothers' ability to open up - giving them "*permission to talk*". However, family relationships were sometimes highlighted as being a significant barrier to MTB, hindering mothers' ability to engage in the programme.

Theme 1.2.1. Grandmothers

Many grandmothers were described to be suspicious of MTB and of any involvement with social workers, and as such often discouraged their daughters from engaging in the programme. It was noted that due to the young age and level of vulnerability of many of the mothers, the opinions of their parents had a considerable influence on their decision-making. One practitioner in particular noted the importance of needing to not just consider the mother's history, but also her family's history, when

trying to formulate barriers to engagement. It was explained that grandparents, and other family members, came with their own histories, which raised challenges in a way similar to mothers' previous experiences. Often grandmothers had very difficult experiences of parenting their own children, many received social care involvement, and many had children removed. As a result, these "*ghosts in the nursery*" continued to have influence, as grandparents often brought their own worries and beliefs about professionals and about parenting, which significantly impacted their daughters' views.

Theme 1.2.2. Fathers

Many mothers were in relationships, often co-habiting, with the fathers of their babies. This meant that fathers often played a significant role in caring for the babies, and were described to be "*equally as good, and equally as challenging"* as the mothers enrolled in the programme. Several practitioners spoke about working jointly with both parents, feeling that MTB could not exclusively be for mothers. However, other practitioners spoke about having to carefully negotiate boundaries, and feeling the tension between not wanting to exclude fathers, whilst being mindful that the programme was principally for mothers.

Many advantages of fathers being involved were discussed. In particular, practitioners explained that *"some of the dads have more capacity to do mentalisation and reflective functioning than [the] mums",* suggesting that fathers' abilities and confidence often helped to scaffold mothers' skills. Similarly, fathers often circumvented other challenges – for example, for very "*avoidant*" mothers, having another person present often took the focus of attention away from them and lessened the intensity of the interaction, it also enabled practitioners to "*model*" reflectiveness with fathers, whist not placing any pressure on mothers to respond.

However, fathers also brought challenges, and some were described as being "*obstructive*, and of having "*no interest"* in the programme. They often seemed scared of being judged and suspicious of professionals, creating similar barriers to engagement as mothers. A major challenge of fathers' involvement within MTB was the risk they could bring. When domestic violence was present, or suspected, practitioners explained that it simply wasn't safe for mothers to "*think or speak freely*" or reflect on their feelings. In cases of suspected domestic violence, practitioners also found it difficult to hold on to their own reflective stance as they were always looking out for risk.

1.3. The Environment

The physical environment families were living in, alongside the interaction of many factors within those environments (e.g. crises involving finances or housing), were identified as the source of many challenges when trying to deliver the programme.

Theme 1.3.1. The physical environment

The environments that some of the mothers lived in were described by practitioners as "*oppressive"* and "*neglected", "filthy, dark and depressing*". Initially, this could be a significant barrier to engaging families as mothers were often reluctant to let any professional through the front door. The home environment often seemed to have a significant impact on mothers' mood, with one practitioner explaining that it was "*hard to have many feelings beyond depression when you're there"* [P3]. Another practitioner went on to explain that for several of her mothers with low mood, the environment often "*mirrors their mind*". In addition to influencing mothers' mood, the home environment was also described to have a significant impact on mothers' reflective capacity: mothers had to shut their mind off to "*avoid the horribleness*" of

their situation. Changing the environment (e.g. taking the mother out to a café or play centre) often uncovered previously hidden reflective abilities, sometimes to the surprise of those working with them.

Theme 1.3.2. Crises and chaos

Practitioners described often finding a "*massive mess to unpick*" each time they visited families; issues with housing, benefits, finances and relationships were described as "*relentless*", leading practitioners to feel that they were "*fire-fighting*" and solving crisis after crisis. Many practitioners said that this often shut down the possibility of working towards developing maternal reflective functioning, explaining that "*you can't really just get your manual out and start looking at reflective functioning [when a family is about to get evicted]".* However, not all practitioners agreed that the chaos was a barrier to doing reflective work – some felt that crises could be key in getting to reflective functioning as it led to more natural conversations about mothers' feelings and worries, and encouraged wondering about babies' experience of what was happening.

1.4. MTB Practitioners

Practitioners also spoke about having 'hangovers' from previous roles, explaining that it could be difficult to let go of the way they had previously done things and to give up their previous professional identities and responsibilities. They spoke about the impact the MTB role had on them, both personally and professionally, and reflected on the impact this, in turn, had on the way they were able to work with families.

Theme 1.4.1. Anxiety about getting reflective functioning right

Learning about reflective functioning was described by some practitioners as putting "*new language*" to existing skills. However, other practitioners described it as being an entirely new experience. Considerable anxiety was expressed about whether they were "*doing it right*". Practitioners explained that they sometimes became so "*preoccupied*" by this anxiety that they were unable to think clearly. By reflecting internally about mothers' experiences and wondering about how everything they said and did was going to be received, practitioners could feel "*paralyse[d]"* and "*frozen"* in the moment. However, once they had learnt to stop trying so hard and to "*tune in to*" their own feelings to guide interactions, the reflective stance came more naturally. Practitioners also realised that their fears about "*doing RF right"* were often mirrored in the organisation; they explained that since this was the first time MTB was being implemented in the UK, the NSPCC were also anxious about getting it correct and "*impressing*" the programme's developers.

Theme 1.4.2. Emotional impact of the work

Working with traumatised, isolated families living in poverty could often be a very emotional and difficult experience for practitioners, especially given the intense nature of the relationship they had built with many of the mothers. They spoke about knowing that they (alongside their paired practitioner) were at times the only people in these mothers' lives, leading to feelings of sadness and a sense of "*overwhelming"* responsibility. Some practitioners found it very difficult to switch off from work, feeling that they were always "*carrying*" their families with them. The emotional impact intensified in instances when the programme was not going well. At these times they sometimes felt like a personal and professional *"failure"*, taking considerable

responsibility when parents weren't progressing in the programme. These cases were described to feel "*overwhelming",* leaving practitioners feeling "*depressed and disheartened*".

Theme 1.4.3. Vague boundaries of the role

Practitioners' roles often felt vague and undefined. They explained that there were such high levels of need in the families they were working with, that it sometimes felt like the practical tasks were endless, risking the reflective work of MTB being entirely missed. Disagreements between different managers and supervisors regarding the scope of the role were also highlighted, which often left practitioners even more confused about their role responsibilities.

The undefined role was also said to impact their relationships with other professionals. Some practitioners described feeling "*powerless*", explaining that their concerns and opinions were "*not taken seriously*" or "*valued*" because no one (including themselves) really knew what it was that they did, what they provided or what they could speak to. However, practitioners also spoke about the benefits of having a less defined role. The flexibility that was afforded allowed practitioners to be present with mothers and "*be whatever the[y] need*" them to be, which was described to be very useful when engaging families.

1.5. Organisational Level

MTB was situated between and within agencies with divergent aims and responsibilities (e.g. NSPCC, Social Care), and practitioners described experiencing tensions between these organisations. One particular tension was in regards to risk. Whereas practitioners felt that MTB was designed to hold the risk and work to reduce it, they felt the NSPCC was quick to communicate concerns to statutory agencies. For

practitioners, this could often damage relationships with mothers and make it harder to effectively work with the risk. A lack of integration between agencies and management structures with regards to managing risk created a very difficult context for practitioners to work in. Although positive working relationship with other organisations had been built in many instances, when there were disagreements, practitioners experienced a battle between organisations, where the mothers and babies were forgotten about.

Theme 1.5.1. Internal systems and requirements can shut down reflection

Practitioners spoke very positively about the organisation they worked for and their managers; however, it was also acknowledged that at times some of the structures within the organisation were in conflict with the ethos of MTB. This had an impact on practitioners' work with families and their ability to sustain a reflective stance. In particular, reporting and recording policies and the volume of supervision were highlighted as particularly challenging, alongside issues with access to technology and resources.

Significant issues were raised regarding the level of bureaucracy where practitioners felt that there was a conflict between certain "*stringent"* organisational policies and procedures and the "*flexibility"* of the MTB program. Although it was widely acknowledged that recording was vital, especially around safeguarding, there was a sense that the level and type of recording was not helpful to practitioners, rather it was there to enable their manager to monitor their work. Practitioners reported that they felt "*scrutinised*", "*judged*", and "*over-monitored*". The level of bureaucracy significantly impacted the way in which practitioners worked with families; for example, several practitioners explained that at times in sessions they became aware that they

were going through mental checklists of how they were going to record certain information rather than being present in the moment. The level of reporting also left them with little time to reflect, and no "*space in [their] head to think".* Practitioners described struggling to hold their families in mind, as instead of reflecting on the content and quality of a session, they were rushing back to the office to record the factual events of the session.

Nearly all practitioners expressed the view that the quantity of supervision was overwhelming. At times this led some practitioners to feel "*deskilled"* with "*little room for autonomy".* Practitioners also voiced concerns that repeating mothers' stories and their own experience of mothers so frequently detracted from them being "*real*" with mothers in the moment, explaining that it ended up feeling like a rehearsed script. There were mixed views regarding group supervision, with some practitioners speaking very positively about the experience, whist others reflected that their head felt "*too full of [their] own cases to hear about other people's"*. Interestingly, the language used to explain what this felt like (e.g. "*my head is too full*", "*no room for reflection",* "*I just switch off*") was very similar to the language used by practitioners when explaining what it was like for mothers who were asked to reflect at a time when they were unable to do so. Practitioners also explained that some types of supervision were more helpful than others. There was a sense that the most useful supervisions were those in which practitioners felt they had a strong relationship with their supervisor and felt safe to share their experiences and talk deeply about cases – where they felt "*held in mind*", whilst supervision which was less focussed on the relationship was sometimes described to feel more like a "*tick-box*" exercise.

Finally, several practitioners highlighted that not having access to suitable working technology or resources (e.g. for video work) meant that they were not able to

provide MTB according to the manual. The stress of trying to get technology to work often led practitioners to become engrossed and preoccupied by the technical difficulties, thus reducing their ability to be present or reflect in the moment.

Theme 1.5.2. Social care involvement

Statutory child welfare services (social care) were often involved with many of the families practitioners were working with, and the significant challenges this brought were frequently detailed.

Practitioners felt that social care involvement often shut down openness, as the safe space that had been created for reflection became a potential source of judgment for mothers. Practitioners highlighted the tension between the aims of MTB and mothers' beliefs about social care involvement. MTB aimed to encourage mothers to reflect on their feelings and experience. However, if mothers felt judged or believed their child was going to be taken away from them, they were less able to be open, particularly about times they were finding difficult (as all new parents have), because they believed that anything they said would be shared with social care. Similarly, practitioners wondered whether the threat of losing their child made thinking about their own feelings and those of their child too threatening, resulting in many mothers "*shutting off*".

Social care were often involved with families at the point of enrolment in MTB, and in many cases were the referrer; practitioners detailed numerous instances when participation in MTB was included on child protection plans prior to birth. Practitioners suspected that this led many mothers to feel that participation in MTB was mandatory or at least necessary in order to keep social services "*off their back"*, and as such were often not fully signed up to the aims of the programme. These mothers' engagement

was said to feel more "*superficial"*, and practitioners described them as being "*guarded*" towards professionals, thus preventing them from building meaningful therapeutic relationships.

Practitioners felt that they were often in a unique position to see the most safeguarding concerns. They spent considerable time with families and had developed trusting and strong relationships with mothers, which encouraged discussions about potential concerns, such as domestic violence, that might otherwise have gone unnoticed. Therefore, it was likely that MTB practitioners were the professionals who were going to identify safeguarding issues. Practitioners explained that this created an "*ethical"* tension; they spent considerable time trying to build trust so that mothers felt safe to open up, but at the same time knew that if they were successful in doing so, they might then have to break that trust if concerns were identified. As a result, mothers could often feel betrayed and let down. Practitioners also explained that once a safeguarding concern had been raised, they were often recruited to assist with parenting assessments by social care, which entirely changed the essence of their role and often led mothers to become very suspicious, believing practitioners were "*spying"* for social workers.

Practitioners reflected that their relationship with mothers was key in overcoming these challenges: if they had managed to develop a strong and trusting relationship with families, mothers could hear and recognise their concerns more readily. In addition, wondering with mothers about what it must be like for them to have social care and MTB involved in a really open and honest way was highlighted as being extremely valuable.

1.6. Wider Culture

Practitioners acknowledged that attitudes and beliefs commonly held within the wider community often had a significant impact on both the families they were working with, and the therapeutic work they were doing.

Theme 1.6.1. Common attitudes

Practitioners explained that it was unusual for people in the communities they were working in to speak in positive terms. As a result, encouraging mothers to be positive in their interactions with their babies was very unfamiliar and didn't fit with mothers' experiences. Similarly, practitioners felt that the culture in which their families lived did not promote thinking about feelings: this was not valued, and was probably discouraged by both their families and the wider community. Again, this had a significant impact on mothers' ability and willingness to reflect, and also meant that any positive changes that were achieved were likely to be challenged by others.

Theme 1.6.2. Cultural perception of agencies

Many practitioners spoke about the public's perception of the NSPCC, and highlighted the impact that national advertising campaigns had on beliefs that the NSPCC targets families who abuse their children, which was in contrast to the aims of the preventative nature of MTB. This belief was felt to be commonly held by mothers, and many other members of their communities. The stigma of NSPCC involvement was thought to have prevented some families from engaging with the programme.

Domain 2: The Essential Components

Practitioners felt that the actual nature of the reflective work involved with "minding the babies" was not problematic; rather, the challenges centred around getting to a point where that work was possible. They identified several essential components of MTB which enabled them to engage mothers and facilitate reflective work. These are summarised in Table 3. Table 4 provides illustrative quotations for each category within this domain.

Table 3.

Categories and themes in Domain 2: The Essential Components

Category	**Themes and sub-themes**
2.1 Relationships are Key	2.1.1 Importance of building relationships early
	Building relationships before babies are born is crucial
	Qualities of successful early engagement
	2.1.2. Giving mothers a difference experience of relationships
	The importance of 'wondering out loud'
	2.1.3. "My other half": Paired practitioners' working relationships
2.2. "Minding Mums"	2.2.1. Keeping mothers in mind
	The importance of wondering internally
	2.2.2. "Start where mums are at"
2.3. Supervision:	2.3.1. Essential components of clinical supervision
Feeling held in mind	Validation of practitioners' emotional experience
	Helps mentalise mothers
	2.3.1. Experience of supervision mirrors relationships with mothers

Table 4.

Illustrative quotations for each category in Domain 2.

Categories, themes and illustrative quotations
2.1 Relationships are key
"What we're doing wouldn't work if you didn't have that relationship, you couldn't go in and start talking about reflective functioning and their feelings and their emotions and their history if you didn't have a really solid relationship with them, a trusting relationship, they just wouldn't…" [P1]
2.1.1 Importance of building relationships early
"I think that once the baby is here, I think it's much more difficult to go back. So, that initial assessment time, where you need to get to know them. If you go in and start probing and asking about their family history and their life line, in the first couple of visits, then you're the social worker, and most of them have had social workers and other professionals and it's not a new experience for them to do that kind of work" [P2]
2.1.2. Giving mothers a difference experience of relationships
"For a lot of young people it's different to be asked what they think about something and how it makes them feel. I think for a lot of [our mums] don't have a lot of experience of being asked that. Or feel anybody else is interested in how they feel, what they think." [P8]
2.1.3. "My other half": Paired practitioners' working relationships
"I think a lot of our cases have been quite hectic, chaotic, difficult to be around, having another person that goes in there just as regularly as you do to see what you're seeing and feel what you might be feeling is really useful. Because sometimes trying to articulate to somebody who's not been in there, what it's like, is difficult" [P8]
2.2. "Minding Mums"
2.2.1. Keeping mothers in mind
"If you've guessed what's going on in her head she knows you understand her…I think for her it makes her think, oh, they do understand how I feel and what's going on. And it also gives her permission, a lot of the times they speak and say what she thinks" [P1]
2.2.2. Start where mothers are at
"I think the main part is just going from where the mum is on that day, and not from the past, just taking the present as a real starting point, from when they are answering the door. Really recognising their physical presentation and their mood. Recognising those things. I think that's probably the crucial part" [P7]
2.3. Supervision: feeling held in mind
2.3.1. Essential components of clinical supervision
"I think sometimes it can make you make sense of the feelings that you've got, or they can just clarify that the feelings that you've got are all right, because sometimes they can be negative feelings, you know, like that family is really frustrating, I find it really difficult going there…And I think having that supervision can be like, okay, let's unpick that…and I think you can come away and you feel a bit more like it's making sense again" [P9]
2.3.1. Experience of supervision mirrors relationships with mothers
"You feel a bit embarrassed by it all, it's like everyone is expecting you to talk about your feelings…and it's not something you've ever done before…I mean, is a completely new experience for me, and if I'm being really honest, you know to start with it was a bit like "ohh…I don't know if I'm really comfortable with this. I don't want to tell you how I feel, or anything like that". And there still are times where it can feel a bit [scary]" [P2]

2.1. Relationships are Key

Practitioners consistently explained that the most vital part of the programme was their relationships with the mothers; without a "*solid foundation*", it was not possible to engage them in any reflective work. "*Trust"* and a feeling of relational "*safety*" were said to be necessary for mothers to feel able to begin to explore their own experiences, thoughts, and feelings, and to contemplate those of their child.

Theme 2.1.1. Importance of building relationship early

Practitioners spoke about the importance of having the time to build these relationships early in the programme: they had noticed that the "*strongest*" relationships they had with families were the ones where they had a long and gentle early engagement period. The opportunity to help with practical issues (such as housing), and make important improvements alongside being able to give mothers a positive sense of what a relationship with MTB practitioners would be like, helped to develop strong and trusting relationships.

Practitioners noticed a qualitative difference between the mothers they felt they had spent enough time with in the early engagement phase, and those who had been referred much later; the latter were felt to be more likely to disengage from the programme, and their relationships were described as more "*superficial*", more focussed on practical issues, and lacking trust. Without enough time in the early engagement phase, it became harder to go back and get to know mothers, which in turn made it harder to tailor the intervention to their individual needs.

Using a "*gentle*", "*paced*", "*non-pressured*" approach to early engagement was described to have a very positive impact on building early relationships with mothers. Practitioners highlighted the importance of informing mothers that MTB was a voluntary programme, and then acting in a manner that reflected that: ensuring the

approach taken was never "*pushy",* empowered mothers to decide what they wanted for themselves and their baby. A flexible approach was identified as essential; as each mother needed something different during the early engagement period, it was important to be able adapt the approach, e.g. it's intensity, formality and directness.

The "*solid [relational] foundation*" achieved by such flexible and gentle engagement allowed practitioners to overcome other challenges as they arose throughout the programme; it enabled them to challenge mothers when needed, navigate difficult and often very painful conversations about mothers' own histories, and discuss concerns and risks in a way in which resulted in mothers being able to hear those concerns.

Theme 2.1.2. Giving mothers a different experience of relationships

Despite discussing the many barriers and challenges to building relationships, practitioners spoke about factors that allowed them to forge meaningful connections with mothers and their families. Many descriptions highlighted that practitioners were providing mothers with a different experience of being with others. For instance, descriptions of the qualities of practitioners' relationships with mothers were often contrasted with explanations of how mothers' previous experiences with both personal and professional relationships had often been characterised by the absence of these qualities. There were several recurring ideas about the relational qualities that practitioners felt were particularly relevant. Mothers had often discussed with practitioners the importance of knowing that they would "*keep coming back*", and "*won't give up*" on them. Practitioners spoke about the importance of understanding mothers' attachment histories and recognising that it was likely these mothers would try to push others away. Many of the mothers they worked with often wanted to keep

professionals "*at arm's length*" and tried to "*put them off"*, frequently to great success. Practitioners highlighted the importance of consistently being there for mothers and repairing relationships when ruptures or disengagements occurred, demonstrating to mothers that they weren't going to give up on them.

An additional quality of the relationship highlighted as important was related to the programme's key component of reflective functioning. Although practitioners explained that a "*solid relationship*" was necessary to engage mothers in reflective work, they also spoke about the central role reflective functioning played in building those relationships. 'Wondering out loud' about mothers' worries and fears and helping them to name their dilemmas or conflicts (e.g. wanting to open up and talk, but being scared of what the practitioner might think or do) were highlighted to be especially important during the engagement phase. Constantly reflecting about mothers' experience and showing genuine interest and curiosity about what they thought and felt was described to foster "*deep*" relationships and give mothers an experience of being "*valued*", "*cared for*", and having someone "*interested"* in them. This was often contrasted with examples of mothers' experiences of more directive approaches often taken by professionals, which were explained to be focused on "*instructing*", "*teaching"* or giving mothers information, often leading mothers to feel judged or powerless.

Theme 2.3.1. "My other half": Paired practitioners' working relationships

Working closely with another professional was a very new way of working, and practitioners highlighted the important benefits it brought. Many of these benefits were practical, such as the sharing of workloads. However, the "*essential"* part of working in a pair was described by nearly all of the practitioners to be about the relationship. They often referred to their pair as their "*other half*" and described the

partnership as *"invaluable"* and as an essential "*sounding board"*, where both partners knew the family equally as well and could therefore offer meaningful insights into their challenges and strengths. This also afforded practitioners the opportunity to check out their feelings with someone who genuinely understood the context. Having a partner who really knew the family reduced the level of "*uncertainty*" or "*unease*" practitioners felt when trying to make sense of complex situations, which reduced anxiety and felt "*containing".*

The level of "trust" practitioners had with their partner was emphasised, with practitioners explaining that it felt safe to reflect and 'wonder' about families within their partnership, and to share their own feelings and frustrations. Several practitioners spoke about how it sometimes felt that "*other people don't want to listen to how awful"* some of the situations they encountered could be*,* but that their pair was always there to listen to their feelings and help make sense of them. This was described as very supportive, like their pair was "*holding [them] in mind*" and always tuned into how they might be feeling.

2.2. "Minding Mums"

Practitioners explained that each family they work with had their own set of unique strengths and challenges, and a "*route to reflective functioning"* needed to be formulated for each mother. Mentalisation was spoken about as being the core component of MTB that enabled this; practitioners explained that reflection was crucial when trying to engage mothers, build relationship and do the reflective work.

Theme 2.2.1. Keeping mothers in mind

Many examples of useful practice with regards to building relationships with mothers and engaging them in reflective work were detailed, however, there wasn't a

'one size fits all' list of what worked. From the examples provided, it was clear that each mother brought a complex set of unique challenges and strengths. It was therefore important to identify these and tailor the approach for that particular family accordingly. Practitioners explained that the programme was often more about "*minding mums*" - really knowing and understanding mothers, their history, their attachment style, their beliefs and ways of making sense of the world, and using this information to formulate how best to intervene.

Practitioners described constantly mentalising about mothers' experience; these reflections were not necessarily shared with mothers, but helped practitioners to understand their presentation and behaviour and in turn formulate what they needed to do to help. They emphasised the importance of being tuned into mothers' reactions, wondering to themselves about how mothers might be experiencing the situation or their intervention, and adjusting their approach accordingly. Examples of this happening at the micro-level were often given; practitioners explained that before asking a question, or making a comment they would already be wondering about how that particular mother was likely to experience or interpret what they were saying. This skill was said to take a long time to develop, and required practitioners to have confidence in their own reflective abilities. Supervision was highlighted as being essential in supporting the development of these skills and abilities.

Theme 2.2.2. "Start where mums are at"

Practitioners highlighted the importance of respecting where mothers were at, both in the moment and more generally, and tailoring the programme to their needs and capabilities. In one sense, this required practitioners to recognise what mothers needed each time they met them at the front door, and adjust their session

accordingly, irrespective of any plans or ideas they might have had for the session. In a more general sense, with regards to reflective functioning, this referred to the importance of identifying what mothers' skills and capacity were, and working at that level, rather than having any expectations about where mothers *should* be at.

Practitioners gave an abundance of examples illustrating the intricate ways they had learnt to tailor the programme on the basis of what they felt each mother needed at any given time. They had observed the "*biggest shifts*" when the programme was tailored in this way. For example, with mothers who were described as "*avoidant*", practitioners found that considering their own history and reflecting on their own experience was often too threatening and caused them to withdraw or "*shut down".* However, practitioners had learnt that for many of these mothers thinking about their baby and reflecting on what they might be thinking or feeling was much more tolerable, and therefore a much more appropriate place to begin the reflective work. Similarly, for some mothers even this was too distressing, and practitioners had learnt that using video clips of other dyads and helping mothers to begin to consider what might be going on in the minds of the mothers and babies in the film was a much more tolerable experience, and allowed mothers to stay within a reflective space.

2.3. Supervision

Clinical supervision was described to be essential in helping practitioners to implement MTB and engage mothers in reflective work. Interestingly, the language used by practitioners to describe their experience of supervision was strikingly similar to the language used to describe their perception of mother's experience of the programme.

Theme 2.3.1. Essential components of clinical supervision

Practitioners felt that "*everyone [was] keeping everyone in mind*", explaining that their relationship with their supervisor felt like a mirror of their relationship with mothers, which in turn mirrored the mothers' relationship with their baby. Practitioners' needs were being kept in mind by their supervisors, who would adjust supervision to cater to what they needed at different times – essentially "*starting where they are at*" on any given day. Being held in mind by their supervisor in such a way left practitioners feeling supported and valued.

Practitioners also felt they were given "*permission*" to feel what they felt: their emotional reactions to families and situations were "*validated*" by their supervisors - it was "*okay"* to feel that way. This was beneficial for several reasons. In some instances, having someone acknowledge how difficult and distressing some of the situations they experienced with families were felt to be "*containing"* and "*reassuring"* – practitioners felt "*heard*" by their supervisors. Discussing their feelings about a case also allowed exploration of these feelings, which helped practitioners to make sense of them. This was described to be particularly useful in instances where there were a lot of concerns; practitioners felt that gaining some understanding and insight into their own feelings and how this connected with mothers' experiences helped to "*contain*" and "*hold*" their worries. Finally, understanding how their feelings linked with mothers' experiences allowed practitioners to rely on their feelings more in sessions, and gave them the confidence to start to share and reflect on their experience in the moment with families.

Feeling "*held in mind"*, alongside exploration of their own emotional experience, helped practitioners to mentalise and 'wonder about' mothers' experiences. "*Constantly mentalising about mums*" in order to make sense of the

complexity and gain insight into what might be needed to help was described to be the essential component of supervision. Gaining these rich understandings about mothers in supervision enabled "*route[s] out of the chaos*" towards focussing on reflective functioning to be identified. Having a better understanding of mothers and a good formulation of their presentation meant that practitioners were better able to anticipate setbacks and make sense of mothers' decisions, particularly when they appeared not to be in their best interest (e.g. returning to an abusive partner). This increased insight lessened the emotional impact and confusion when setbacks occurred, and helped practitioners to better understand the challenges they were facing and to adjust their expectations accordingly.

Theme 2.3.2. Experience of supervision mirrors relationship with mothers

Practitioners explained that their relationship with supervisors often felt like a template for their relationships with mothers, and the words that they used to describe their experience of supervision were strikingly similar to those they used to describe mother's experience of the programme.

Practitioners used several phrases repeatedly to capture their experience of being supervised, explaining that this type of supervision was an "*entirely new experience*", where previously they hadn't had a space "*just for them*", weren't used to talking about their own feelings and had "*never had the interest [from another professional] in [them], and [their] feelings*". At first they had worried about being "*judged*" and "*struggled to trust"* their supervisor, who was often described to have felt like a very impressive expert. Practitioners found it very difficult in the beginning to openly name what they really thought or felt, and worried that doing so would invite criticism. These descriptions shared many similarities with the ways in which

practitioners spoke about how they supposed mothers felt about them during early engagement. Practitioners also highlighted the importance of their relationship with their supervisor, explaining that feeling comfortable and safe to be open was essential for reflection and exploration. Interestingly, one practitioner explained that having lots of time early on in supervision, before she had any cases to discuss, was crucial in building a solid and trusting relationship with her supervisor and for allowing their supervisor to get to "*know where they are at".* This practitioner went on to reflect that this was "*how it must feel for mums".*

Discussion

Practitioners' accounts demonstrated the complex and diverse presentation of families enrolled in MTB, and highlighted the wide range of factors that create barriers to the translation of the model into practice. Despite these considerable challenges, practitioners described being able to engage families in the programme. Their accounts indicated the central role their therapeutic relationship with mothers played, both in responding to some of the challenges identified, but also in being able to engage mothers in reflective work.

The qualitative accounts highlighted that the challenges of delivering MTB do not exclusively fall within the immediate therapeutic context involving mothers and practitioners, but that the implementation of reflective work is impacted by factors situated within multiple systems – including the immediate family system, the family's wider social ecology, local and national service ecologies and the wider cultural context. An ecological-systems model (Bronfenbrenner, 1979) provides a useful theoretical framework for understanding the challenges identified. This model emphasises the complex and multi-systemic context in which development occurs, and in turn

highlights the significant influence these multiple ecologies have on development. The results of the current study demonstrate not only the complexity of the families MTB is working with, but also the complexity of the context in which the work is being delivered; barriers at various levels of context impacted the success with which practitioners were able to implement the programme and engender meaningful clinical outcomes. Similar systemic challenges have been highlighted within other mentalisation-based approaches. For example, AMBIT (Bevington & Fuggle, 2012), a mentalisation-based integrative intervention for hard-to-reach adolescents, emphasises the challenges faced by working with clients who have complex networks involving multiple agencies. Disagreement between workers and agencies is highlighted as common, particularly regarding the way the problem is conceptualised, the pragmatic solutions proposed and the assumptions regarding role responsibilities within the wider system of care (Bevinton, Fuggle, Fonagy, Target & Asen, 2014). Bevington and Fuggle (2012) propose that difficulties and disagreements in the young person's networks cause multiple threats to building and sustaining relationships (both therapeutic and professional) and can result in aversive experiences of care, despite the best intentions of the workers involved.

Some of the challenges highlighted by the MTB practitioners can be conceptualised as failures to mentalise throughout different social or organisational systems: mothers struggled to contemplate their own mental states and those of their infant at times of crisis, practitioners' emotional reactions to working with such high-risk and high-need families sometimes interfered with their ability to hold a reflective stance, and organisational disagreements about the management of risk disrupted professionals' ability to hold the family in mind. These difficulties highlight the

importance of creating systemic conditions which support the development and maintenance of mentalisation at every level.

Being faced with considerable complexity and risk, practitioners experienced high levels of professional anxiety and stress. Working with high-need, multi-problem families can challenge even the most experienced professional, especially where there are safeguarding concerns, and can result in a breakdown of mentalisation and reliance on 'action' rather than 'reflection'. This is especially likely when working in community outreach services where there is an increased tendency for professionals to feel isolated from professional support structures (Munro, 2010). Emotional reactions to working with such complexity resulted in significant barriers to practitioners' capacity to maintain a reflective stance. The mentalisation framework explicitly deals with the way in which stress undermines the capacity of mentalising and reflection; mentalising and high emotional arousal are in a reciprocal relationship, whereby the activation of one tends to deactivate the other (Allen, Bleiber & Haslam-Hopwood, 2003).

Some specific features of MTB helped to mitigate these difficulties, and were highlighted as 'essential components' of the model within practitioners' accounts. Both the clinical-supervisory model and working closely with a paired practitioner helped to contain anxiety, fostered a sense of support and left practitioners feeling 'held in mind'. These factors highlight the importance of providing robust support and professional compassion for staff working in out-reach and home-visiting models with high-need, complex families. Furthermore, it was evident in the qualitative accounts that the quality of professional relationships played a crucial role in supporting practitioners' capacity to deliver reflective interventions. Ferguson (2011) highlights the need for social workers and other professionals working in the child protection arena to have adequate professional support, drawing parallels between workers' ability to attend to

and support families and the quality of support, care and attention they themselves receive from supervisors, managers and peers. Whilst the literature examining the processes involved in reflective supervision highlights the importance of exploring practitioners' emotional reactions and responses to the families they work with, alongside considering the links between practitioners' emotional experiences and the parallel experiences of their families (Weatherson, Weigand & Weigand, 2010), the supervisory model within MTB appeared to take this a step further. It was not just the exploration and validation of feelings that was important to practitioners; the relational experience of being supported and 'held in mind' by their supervisor was crucial in enabling practitioners to think reflectively about their families.

In addition to the barriers to mentalisation evident within the therapeutic context, the effects of disagreement and tensions between and within organisations also had a significant impact on the work practitioners were doing with families. Prescriptive and rigid organisational procedures were experienced as being implemented in an essentially non-mentalising way, seemingly without consideration of the impact they might have on other people in the system. Similarly, disagreements regarding the level of risk or responsibilities between organisations resulted in a lack of integration between the systems (e.g. NSPCC and social care) supporting families. In these instances, the experiences of those exposed to such interactions (both families and professionals) were often not considered – mirroring the disintegration and non-mentalising interactions within families that MTB aims to prevent. This is particularly important when considering the specific context in which MTB was delivered; the NSPCC is primarily a safeguarding organisation, where child protection and legal responsibilities to report risk need to be balanced with the ability to deliver effective preventative interventions.

Both Lord Laming's review of the protection of children in England (2009) and the Munro review of child protection (2010) argue that anxiety about managing the uncertainty inherent in child protection work shapes professional practice in adverse ways; professional practice and judgment are often compromised by the reliance on management tools focused on compliance with procedure. Such regulatory systems can impede professionals' capacity to engage in direct face-to-face interactions with children and families, and are ultimately distanced from the reflective practice that enables professionals to manage the emotional dimensions of the work whist minimising any negative impact on their judgment or well-being.

The multiple domains in which challenges were identified within the current study demonstrate that it is not just the direct therapeutic context that must be considered when trying to maximise positive outcomes for families, but that the context in which these interventions are delivered and how they are supported by the organisations delivering them are integral to their success. Mentalisation-based practice can be applied not only to direct therapeutic work, but also towards the teams and organisations delivering the interventions and parts of the multiagency networks working with each family. This approach has been instigated within other mentalisation-based interventions (e.g. AMBIT, Bevington & Fuggle, 2012) where mentalisation-based practice is applied within multiple systems: with families, teams, within supervision and between agencies to reduce disintegration.

Practitioners' accounts also highlighted the importance of the therapeutic relationship, supporting the predicted MTB mechanisms of change (Sadler et al., 2006; Slade, 2006; Slade et al., 2005); the reflective work involved in MTB was perceived as not being possible if it were not for the strong and trusting relationships practitioners managed to build with mothers. The importance of the therapeutic relationship is not

new; previous research has demonstrated robust associations between the therapeutic alliance and positive outcomes (Hovarth & Symonds, 1991; Martin, Garske, & Davis, 2000; Shirk & Karver, 2003), nor is it specific to MTB. Qualitative accounts given by practitioners delivering the Family Nurse Partnership (FNP; Olds, Henderson, Tatelbaum & Chamberlin, 1986), a home-visiting programme working with high-risk families, identified similar relational qualities essential to engaging and retaining families (Ingoldsby et al., 2009). However, the gentle, responsive, non-pressured approach to engagement and building relationships taken in MTB may be especially important with families whose histories have often been characterised by trauma and neglect and who have frequently had negative experiences of professionals.

In addition, practitioners' accounts highlighted the importance of specific features of MTB which were instrumental in facilitating positive relationships with mothers, suggesting that reflectiveness is both an essential component of building relationships alongside being a positive outcome resulting from them. In that sense, the practitioners highlighted the fundamentally relational nature of mentalisation (Fonagy et al., 2003). Bowlby discusses the importance of developing 'therapeutic attachments' with clients, suggesting that the activation of the attachment system in relation to the professional is likely to be an important component of treatment for some patients, essentially establishing a 'secure base' from which they can explore their own internal world (Bolwby, 1977a; 1977b). Fonagy et al. (2003) argue that there is a mutually facilitative relationship between the attachment and mentalising social systems; feeling secure in a relationship makes it more likely that a person will understand the behaviour of the other in relation to their underlying mental states, and understanding the actions of another in terms of their underlying thoughts and feelings triggers affiliative reactions. This provides a helpful way of understanding the mutual interplay

between mentalisation and relationships for mothers in the MTB programme: mothers' experience of someone who is both interested in, and values, their thoughts, feelings and worries is often a very new, and powerful experience. Successful mentalising in this context fosters a sense of being heard and understood, which promotes meaningful therapeutic relationships. This theme is apparent in all relationships within MTB; the emphasis is echoed in the supervisory relationship and relationships between paired practitioners and other team members.

Methodological limitations

All participants were actively delivering MTB at the time of their interview; it is therefore possible that they were motivated to appear in a favourable light and speak about their role positively. This may be especially relevant as all participants were aware that the current qualitative research study was linked to a wider RCT evaluating the effectiveness of MTB, which would ultimately contribute to decisions regarding the wider roll-out of MTB throughout the organisation. In addition, despite assurances before interviews that the research team was entirely separate from their employers, it is possible that practitioners were reluctant to openly discuss aspects of the service and intervention of which they were more critical. Before the interviews began it was emphasised that the qualitative research would contribute to the pilot phase of the main RCT, and aimed to improve implementation and practice before the RCT began in order to maximise outcomes, which may have ameliorated some positive bias. In addition, throughout the interviews practitioners appeared to speak openly and highlighted both positive and negative aspects of the programme.

A further issue concerning the quality and validity of the accounts given by practitioners relates to the reliance on retrospective recall of detailed clinical and

professional interactions and experiences, which is a potential source of bias (Giorgi & Giorgi, 2003), as accounts may have been subject to distortion over time. However, interviews took place whilst practitioners were delivering the programme which may have aided recall. In addition, as practitioners were well versed in mentalisation, they were probably particularly skilled at recalling detailed interpersonal interactions and experiences.

An additional consideration pertains to the generalisability of the findings to different contexts. The current research focussed on the implementation of MTB in the UK, and therefore caution should be exercised in generalising the findings beyond this context. Local difficulties were identified in each of the three sites delivering MTB, and many differences between the challenges of implementation of MTB in the UK and the US context were highlighted. It is therefore important to be mindful of the specific context when considering the applicability of the results of the current study.

Implications for future research and practice

Multi-informant qualitative research examining the experiences of multiple stakeholders, such as the mothers and families receiving MTB, the practitioners delivering MTB and the supervisors and managers supporting the programme would offer a rich picture of the challenges and facilitators of engagement in and implementation of the programme. This would be especially informative if used in combination with relevant quantitative measures, such as measures of therapeutic (or supervisory) alliance, level of trust in relationships, and levels of anxiety or stress. Results of such research could be used to refine the programme and its implementation, with the aim of improving outcomes. Additional research is necessary

to examine whether such refinements or adaptations improve the programme's efficacy.

A number of clinical implications are raised by the accounts of the professionals delivering MTB. Firstly; the importance providing robust professional support for practitioners delivering interventions to high-need, multi-problem families was highlighted, especially when there are concerns about risk and safeguarding. The relational experience of being 'held in mind' by their supervisors and colleagues was crucial in enabling practitioners to think reflectively about their families and to feel emotionally and professionally supported. When implementing complex interventions within complex family systems, organisations and supervisors need to ensure that the practitioners working directly with families are supported within their work by teams that promote reflective practice (including the provision of reflective supervision), provide strong peer support, work cohesively and share expertise; an approach which is consistent with other mentalisation-based interventions' focus on ensuring there is a strong 'team around the worker' (Bevington et al, 2013).

Secondly, the research highlights the impact factors outside the immediate therapeutic relationship have on programme implementation (and successful delivery of mentalisation-based interventions). Organisations need to consider the context in which mentalisation-based parenting interventions are delivered, paying particular attention to how interventions are supported, and the impact of organisational policies and procedures on other people in the system, especially mothers, and those working directly with families. Clinical Psychologists have key skills in working within complex organisations and thinking systemically, and are positioned to intervene at different levels of the network, including within the organisation delivering the therapeutic intervention itself. Identifying, formulating and addressing barriers to successful

programme implementation (and successful mentalisation) at multiple levels or the system is essential. Improvements in the organisational support of interventions, and practice which supports the development and maintenance of mentalisation at every level of the system, is likely to lead to better implementation of programmes and ultimately result in better outcomes for families.

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Part 3: Critical Appraisal

Introduction

This critical appraisal explores the process of conducting the research presented in Part Two. Firstly, I will reflect upon practitioners' observations regarding the differences between the context in which MTB was developed, in the United States, and the context in which it is being implemented in the UK, with reference to research examining the transportation of evidence-based interventions. Finally, the process of conducting qualitative interviews with professionals and carrying out qualitative analysis will be discussed.

Implementation science: how can interventions be transported successfully to different contexts?

The overarching question that drove my research was concerned with how to effectively deliver and implement a complex intervention with high-need and high-risk families. An issue germane to this question is where the intervention is being implemented. MTB has been transported to the NSPCC in the UK - a setting far from the research environment in which it was developed (Yale University) and the setting it was initially implemented (New Haven, Connecticut, USA). The challenges of implementation in the UK, as opposed to the US, are likely to be different given the very different contexts. The following discussion will briefly detail the challenges highlighted in practitioners' accounts relevant to the UK setting, and then consider the implications of adapting interventions to suit local requirements, balancing this with consideration of the importance of model fidelity.

Throughout practitioners' interviews, the differences between the UK and the US contexts were frequently discussed, highlighting challenges that were relevant to one context rather than the other. Most pertinent within practitioners' accounts were

the differences in families' situations; fathers were said to be present in the majority of their cases, whereas in the US the majority of mothers were said to be single parents (demographic details from the first wave of outcomes from the RCT conducted in the US indicate that 84% of mothers enrolled in MTB were single; Sadler et al., 2013). Practitioners explained that it was evident during their Skype supervision with Yale researchers that fathers were almost never involved in the intervention in the US. As discussed in the empirical paper presented in Part Two of this thesis, fathers brought a range of both challenges and benefits to the programme. Practitioners sometimes found it difficult to work successfully with fathers as there was no provision within MTB for including them in the intervention or for working with difficulties often present in the parents' relationship.

In addition to differences in family composition, significant differences between local service provision contexts were also identified by practitioners. These included perceived differences in the availability of adult (or adolescent) mental health services for mothers, and more significantly, the differences between the statutory provision of child welfare services. In particular, practitioners referenced the NSPCC's greater legal duties to report risk to statutory agencies, and the fact that social care were involved with a significant proportion of families MTB was working with in the UK. These differences in context brought a very different range of challenges to the practitioners delivering MTB in the UK, which may not have been present in the US where the programme was developed. Finally, differences in both the geographical location (i.e. MTB is delivered from a single community health care centre in the USA, whilst in the UK it is delivered across several regions with no central hub) and local attitudes towards receiving therapy and "talking positively" were also discussed.

Many practitioners voiced ideas about how MTB could be adapted to suit local

needs. For example, in reference to differences in family composition, practitioners suggested that the programme should be adapted to include working jointly with both parents or should be made available equally to mothers and fathers, and that the programme should incorporate a couples therapy component. These suggestions make sense, given both the challenges and benefits fathers brought to the work. However, there has been a debate in the scientific literature over whether adaptation of evidenced-based programmes is acceptable (O'Conner, Small & Conney, 2007), with many asserting the importance of maintaining fidelity to the model – a goal often considered indicative of the successful transportation of an intervention. In order to consider potential adaptations of MTB, as suggested by practitioners, it is first important to consider the literature regarding the successful transport and implementation of interventions, the goal of model fidelity, and the impact of adaptation on clinical outcomes.

The field of implementation science examines methods to promote the integration of research findings and evidence-based interventions into healthcare policy and practice, and is essentially concerned with how to successfully establish evidence-based interventions in routine settings (Eccles et al., 2009). Developing a successful intervention (as evidenced by RCTs establishing effectiveness at achieving relevant clinical outcomes) is only the first step towards effecting meaningful clinical change in the 'real world'; successful implementation, which refers to whether or not an intervention adheres to the treatment principles and manual once transported (Ogden, Amlund, Hagen, Askeland & Christensen, 2009) has consistently been shown to result in better clinical outcomes (Durlak & DuPre, 2008).

Derzon et al. (2005) provide meta-analytical data examining the factors related to effect size in drug prevention programmes, and found that two factors with the

strongest impact on outcomes were related to the implementation of the intervention (i.e. the degree to which program objectives and procedures were put into practice and the intensity of programme delivery). Furthermore, Derzon et al. (2005) adjusted their data to optimise the influence of implementation factors, using regression procedures to re-estimate study outcomes. They found that interventions would have been up to 12 times more effective if the issues of implementation were controlled, highlighting how crucial successful implementation is for programme outcomes.

A key factor often emphasised within implementation research is fidelity to the model – i.e. the degree to which the intervention is implemented in accordance with the manual in a given setting (Backer, 2002) – the assumption being that evidence-based interventions will only continue to be efficacious if implemented according to the original programme design. Ogden et al. (2009) also make a helpful distinction between programme fidelity, which refers to whether an intervention is delivered as intended at all levels of an organisation (e.g. the model of supervision, team structure, team ethos etc.), and treatment fidelity, which refers to whether the dosage and exposure of an intervention as well as the core contents of the treatment are delivered according to the manual.

Programme and treatment fidelity, however, are not easy to achieve in practice. Schoenwald et al. (2009) argue that psychosocial interventions are “soft technologies”, which are particularly vulnerable to adaptation when transported to community-based settings. Adaptations may be made in order to better meet the local needs of the community where it is being implemented, to fit within organisational constraints (such as budgets), or to accommodate preferences of the practitioners facilitating it. The authors suggest that such adaptations may compromise the interventions’ effectiveness in matching the clinical outcomes achieved in controlled research

settings.

Programme adaptation, however, has also been shown to play an important role in achieving positive outcomes. In a review examining implementation studies in the field of prevention and promotion interventions for children and adolescents, Durlak and DuPre (2008) conclude that adaptation (e.g. making changes to the original program during implementation) can play a crucial role in achieving positive outcomes. Similarly, Backer (2002) also challenges the idea that programme adaptation indicates an implementation failure. In his review, Backer reports three quantitative studies which demonstrate that adaptations made to interventions improved programme outcomes (Blakely et al. 1987; McGraw et al. 1996; Kerr et al. 1985), concluding that attention to both programme fidelity and local adaptation during the process of implementation is critical.

More recently, the discussion within the literature has moved from asking whether adaptation is ever acceptable, to examining which types of adaptation to local requirements may be helpful, and which might undermine programme effectiveness (U.S. Department of Health and Human Services, 2002). Similarly, Hall and Hord (2001) emphasise that asking "is adaptation desirable?" is the wrong question, suggesting that adaptation is inevitable, and the important questions are "how much?" and "when is the programme's content damaged?". Substantial disagreement among researchers remains, however, with regards to how much adaptation is acceptable in order to meet local needs.

Balancing programme fidelity and adaptation is not a straightforward process; adaptations to evidence based-intervention may dilute their effectiveness, whist applying manualised interventions in a rigid way may be inappropriate to meeting the needs of the community. Backer (2002) suggests that it is important for programme

developers and researchers to identify the “core components” of effective programmes – those elements that must be maintained rigorously in order for the programme to be effective. This research can then be used to inform service developers and practitioners to enable them to develop program implementation approaches that address the fidelity/adaptation balance strategically, so that the core components can be delivered with maximum fidelity, whilst less important features can be adapted to achieve a good ecological fit with local needs. In order to ensure that adaptations do not reduce or eliminate crucial elements of the original intervention in a bid to make them more “attractive” to participants, practitioners or organisations, research is needed to ascertain whether the adaptations made undermine (or indeed enhance) programme efficacy. The results of this in turn need to be fed back to re-adjust the intervention. Adding components to an existing programme, whist otherwise maintaining fidelity, may be less troublesome; adding, rather than omitting, elements reduces the likelihood of eliminating the essential components of the intervention. In fact, Blakely et al. (1987) found that interventions which added components to an existing programme tended to be more effective than programmes implemented without additional components.

In conclusion, it seems that absolute fidelity is not always of paramount importance; adaptation to local requirements may be an equally important contributor to an interventions success. However, it is crucial to find the right balance between maintaining fidelity to the active components of an intervention and adapting it to meet the needs of the community where it will be implemented. The suggestions made by MTB practitioners in the current study to add components to the intervention, such as including relational work between mother and fathers, are less likely to eliminate the essential components of the intervention, and may bring many benefits (or reduce some of the challenges inherent with delivering complex interventions with high-need

families). Adding components focussed on the parental relationship might also help develop reflective functioning if the focus of the work remains on mentalisation, complementing the core aims of MTB. This is especially relevant since tailoring MTB to the needs of each family, and delivering a responsive intervention are also core features of the programme. In addition, the numerous barriers to reflective work that were identified to arise due to difficulties inherent to the UK context (e.g. the challenges related to social care involvement) are likely to impact the success to which MTB is able to effect meaningful clinical change. Further research is needed to examine what changes and adaptations may be needed, and what impact those changes have on outcomes.

The process of conducting qualitative interviews and analysis

The current study was part of a wider research project, which also included another qualitative study exploring the therapeutic processes in MTB from the perspective of the mothers enrolled in the programme (Burns, 2014). During discussions with my colleague who conducted this research, I was struck by the very different experiences we had of carrying out qualitative interviews; whist she experienced challenges in engaging mothers and eliciting rich detail about their experiences of the programme, I was met with enthusiasm from professionals who were highly motivated to share their experiences of MTB. The following discussion will focus on the benefits, challenges and dilemmas faced when interviewing practitioners, as opposed to service users, and will explore the sources of potential bias upon the process of conducting qualitative research with professionals. This is particularly relevant, as there is a dearth of research exploring the experience of practitioners delivering interventions; rather qualitative methods are often employed to examine the

views of those receiving therapeutic interventions (McLeod, 2011).

As discussed in the empirical paper in Part Two, practitioners' accounts could have been influenced by the very fact that they were employed to deliver the programme they were being asked to evaluate. Socially desirable responding (i.e. wanting to protect themselves and MTB from negative judgment) may have led practitioners to give overly positive accounts of their experiences. However, this did not appear to discourage them from providing more critical views of various aspects of the programme. Assurances of the independence of the research from their employers helped to encourage this, alongside specific enquiry about the more difficult aspects of implementation. On the other hand, whilst the practitioners appeared to give open accounts of their experiences, concerns regarding how the information might be used and interpreted – particularly by their employers – were evident in some comments made by practitioners. Explaining that sections of their interviews could be excluded from the analysis at a later date if they had concerns about confidentiality (e.g. if their managers could identify them by the examples they had used) or how the information might be interpreted, was particularly helpful at these times. In addition, using questions that inquired about how practitioners felt the challenges they had identified could be overcome, or what improvements to the delivery of the intervention they would propose, appeared to free practitioners to discuss both the negatives and positives of their experiences.

Researcher characteristics, such as gender, ethnicity and life experience, can exert an influence on the data collected and affect the process of building rapport with participants (Smith, Flowers & Larkin, 2009). My own professional status as a trainee clinical psychologist was known by some practitioners, as was my interest in working with children and families; these factors are likely to have been relevant when

interviewing practitioners delivering therapeutic interventions to families. The fact that I was a clinical psychology trainee studying at UCL was evident on my participant information sheets, and was therefore known to practitioners in advance. However, whether or not to disclose the area I worked in (looked after children) to practitioners was a dilemma I unexpectedly faced in my first interview, when the practitioner, knowing the requirements of the DClinPsy, asked what placement I was currently on and whether I was interested in working with children and families. In the moment, I wondered how my answer might impact the interview, but ultimately answered honestly out of politeness and a wish to build rapport. Avoiding personal disclosures was not something I had ever struggled with when clients asked for personal information, but I found it significantly more difficult to maintain boundaries and not disclose this information when practitioners enquired about my interests.

In hindsight, being open about my professional interests, alongside practitioners' knowledge about my being a trainee clinical psychologist working with children and families, may have brought some benefits. It afforded me the luxury of being both an 'outsider' and 'insider'; I was not from the same organisation or profession as practitioners and was not involved with the delivery of MTB, but at the same time, I was also a clinician working in a similar field to practitioners, and had detailed knowledge of the programme they were delivering.

Being an 'outsider' to practitioners' profession and to the organisation in which they worked may have increased their honesty and openness when discussing more critical aspects of their experience of delivering the programme and of organisational tensions. Furthermore, not being part of the same organisation or profession helped me to elicit individual meanings by adopting a naive, 'not-knowing' stance (Monk, 1997).

Being perceived partly as an 'insider' may have brought additional benefits. My experience of working in a similar, although unconnected field may have avoided some of the pitfalls experienced when participants view the interviewer as being too far removed from their experiences to comprehend the complexities of their work; practitioners appeared to assume that I understood the context in which they worked, evidenced by frequent comments about my presumed own familiarity with, for example, social care and adult mental health services, or clinical supervision. At times this raised some dilemmas; I had to balance attempting to ensure that neither my own, nor practitioners' assumptions regarding our shared experiences obscured me from exploring their individual meanings, whilst also having to decide in the moment which lines of exploration to pursue as not all meanings could be examined due to the overwhelming number of potential avenues.

The literature on qualitative methodology discusses the impact of researchers' previous experiences and assumptions (amongst many other factors such as gender, age and culture) on the way they engage with the data (Fischer, 2009). Researchers are encouraged to be self-reflexive in order to identify areas of potential bias, and then to "bracket" assumptions or previous experiences in an attempt to limit any undue influence on the research (Ahern, 1999; Fischer, 2009). During the process of 'bracketing', the emphasis should be on understanding the effects of previous experiences, rather than attempting to eliminate them in pursuit of 'objectivity' (Ahern, 1999). Ahern (1999) recommends that during the data collection phase the researcher engage in a process of bracketing by writing observational comments, detailing their feelings and thoughts throughout the process of data collection. I kept a research journal, and immediately after each interview recorded any ideas or impressions that arose during the interview. Ahern (1999) suggests that writing such notes can

illuminate preconceptions held by the research, enabling a deeper engagement with the data. I found it particularly helpful to write detailed notes reflecting on the process of conducting the interviews, particularly examining instances when I felt confused or surprised by something the practitioner had said, or times when I wondered how my questions or approach to interviewing may have unduly influenced the way practitioners responded. Returning to these notes helped me to think about the impact my understandings might have on data collection.

Tufford and Newman (2010) explain that tensions often arise between bracketing preconceptions and previous experience, and using them as insight. I attempted to maintain a balance between identifying and "bracketing" my assumptions and own professional experiences, and using them to inform both my approach to the interviews and the development of the research. For example, my knowledge of the theoretical background to MTB was helpful in identifying potentially fruitful avenues of questioning and exploration. Similarly, my previous experience of using systemic and narrative models in my clinical work was particularly helpful during interviews in enabling me to adopt a curious 'not knowing' stance and explore individual meanings. Knox and Burkard (2009) suggest that the strength of the relationship between interviewer and participant is perhaps the single most important aspect of qualitative research, explaining that it is through this relationship that all data is collected. The quality of this relationship is likely to affect participants' self-disclosure, including the depth of information they share about their experiences. Using my clinical skills and previous clinical experiences aided me in building relationships with practitioners, and is likely to have had a positive impact on the quality and validity of the data collected. This provides an example of the importance of reflecting upon the impact previous experiences had on the approach to and engagement with the data, rather than

attempting to eliminate one's assumptions and previous experiences in the interest of objectivity (Tufford & Newman, 2010).

The interviews required practitioners to identify and reflect upon complex internal and relational processes. Asking practitioners who were well versed in mentalisation and reflectivity made this process significantly more straightforward than asking mothers who had limited capacity for self-reflection. Whilst my colleague who interviewed the mothers enrolled in MBT had to work hard in order to gain details about their experiences, I suffered from data-overload, receiving long and detailed accounts from extremely articulate and reflective professionals. A dilemma that was ever present whilst conducting the interviews was how to decide which lines of enquiry to pursue and which to leave, and how to balance building rapport and hearing the concerns of practitioners (which were not always pertinent to the aims of the research), with trying to gain rich detail about multiple areas of interest relevant to the research questions in a limited amount of time.

Conducting 13 two-hour interviews with very articulate practitioners produced a vast quantity of data to analyse. Somewhat ironically, this provided me with a very concrete experience of the overwhelming impact of stress on one's ability to think and reflect, and gave me a new appreciation of some of the challenges practitioners spoke about in this regard. Deciding what to 'foreground' or prioritise in the analysis was particularly challenging given the vast quantity of data. Partly as a result of the enthusiasm and generosity practitioners had shown me in taking part in the research, and partly due to the very positive impression of practitioners that I had developed whilst conducting interviews, I found myself very concerned with not missing anything important and representing all ideas accurately within the thematic analysis. It quickly became evident that it was not possible to achieve this whilst also producing a readable

and practical framework.

Braun and Clarke (2006) describe several common pitfalls of qualitative research, one of which being a failure to actually analyse the data. They explain that researchers can sometimes present a collection of extracts and a narrative that paraphrases their content rather than providing analysis and synthesis. This rang true of my first attempt to make sense of the transcripts, which resulted in a very extensive and detailed summary of what had been said by practitioners. Synthesising this information and constructing an analytic narrative for such large amounts of data was a daunting task. The literature on qualitative methodology describes analysis as an iterative process; the researcher moves back and forth between the data, initial codes and organising framework in order to develop understanding and refine the themes (Braun & Clarke, 2006; Richie & Spencer, 2003; Tufford & Newman, 2010). I engaged in repeated (and lengthy) cycles between the transcripts, my initial codes and emerging themes. I had not anticipated how fruitful each reiteration would be; each cycle resulted in a more refined framework – themes became better defined and demarcated, nuances and contradictions were added and the 'keyness' of ideas became more evident.

Smith et al. (2009) discuss the task of reducing the volume of detail within a data set during the process of analysis, whilst maintaining complexity, suggesting that mapping interrelationships, connections and patterns within the initial codes and explanatory notes is helpful during this process. I found it particularly helpful to print out potential themes and ideas (and sometimes relevant quotes) for each participant, and then cut the list up so that each idea was on a separate piece of paper. This allowed me to organise and re-organise the themes and encouraged exploration of how the different themes related to each other. Printing the themes and quotes for each

participant in a different colour also made it much easier visually to understand the prevalence of key ideas across participants, especially given the substantial quantity of data. It also helped to ensure that I did not give more credence to a few vivid or well-articulated accounts from particular practitioners, but rather helped to make sure that I had given equal attention to each transcript.

During this process, I also became acutely aware of the subjective nature of qualitative research; although I had frequent discussions with other members of the research team to explore possible ways of representing the data, I had to ultimately decide what was prioritised and what was omitted from the final thematic framework. The final themes had not 'emerged' from the data; I had actively constructed them on the basis of my own understandings and interests. Braun and Clarke (2006) explain that accounts of themes 'emerging' from the data implies a passivity in the process of analysis, denying the active role the researcher plays in identifying themes and deciding which are of interest. Therefore, the final themes are a reflection on "not only the participant's original words and thoughts, but also the analyst's interpretation" (Smith, et al., 2009; p. 92).

Conclusions

The accounts given by practitioners provided valuable insight into the challenges of implementing a new intervention in a routine clinical setting. Practitioners gave rich accounts capturing the complexity of the therapeutic process, and identified barriers to successful implementation situated across various levels of context. Their perspective on the challenges of implementation is important in addressing issues of transportability, highlighting potential areas for consideration regarding adaptation to local needs, and informing further research into the impact such adaptations may have on the efficacy of the MTB programme.

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Appendix 1. Description of Joint Project

Description of the Joint Projects

This study was conducted in collaboration with another UCL Clinical Psychology Doctoral Student (Burns, 2014). Both projects were concerned with the challenges of implementing the Minding the Baby programme. Whilst the current study examined the challenges of implementation from the perspective of the practitioners delivering the programme, the thesis by Burns explored the experiences of the mothers who were enrolled in the programme.

Both researchers jointly completed applications for ethical approval and jointly organised and facilitated a focus group with practitioners and managers who were responsible for delivering MTB in the UK. All other work was completed independently. Other than the data collected during the focus group, no data was shared between the studies.

Appendix 2. Letters of Ethical Approval

UCL RESEARCH ETHICS COMMITTEE
GRADUATE SCHOOL OFFICE

Professor Pasco Fearon
Research Department of Clinical, Educational and Health Psychology
1-19 Torrington Place
UCL

29 January 2013

Dear Professor Fearon

Notification of Ethical Approval

Project ID: 4380/001: Minding the baby: the challenges of implementing a reflective functioning parenting programme with high risk families

I am pleased to confirm that your study has been approved by the UCL Research Ethics Committee for the duration of the project i.e. until September 2014.

Approval is subject to the following conditions:

1. You must seek Chair's approval for proposed amendments to the research for which this approval has been given. Ethical approval is specific to this project and must not be treated as applicable to research of a similar nature. Each research project is reviewed separately and if there are significant changes to the research protocol you should seek confirmation of continued ethical approval by completing the 'Amendment Approval Request Form'.

The form identified above can be accessed by logging on to the ethics website homepage: http://www.grad.ucl.ac.uk/ethics/ and clicking on the button marked 'Key Responsibilities of the Researcher Following Approval'.

2. It is your responsibility to report to the Committee any unanticipated problems or adverse events involving risks to participants or others. Both non-serious and serious adverse events must be reported.

   Reporting Non-Serious Adverse Events
   For non-serious adverse events you will need to inform Helen Dougal, Ethics Committee Administrator (ethics@ucl.ac.uk), within ten days of an adverse incident occurring and provide a full written report that should include any amendments to the participant information sheet and study protocol. The Chair or Vice-Chair of the Ethics Committee will confirm that the incident is non-serious and report to the Committee at the next meeting. The final view of the Committee will be communicated to you.

Reporting Serious Adverse Events

The Ethics Committee should be notified of all serious adverse events via the Ethics Committee Administrator immediately the incident occurs. Where the adverse incident is unexpected and serious, the Chair or Vice-Chair will decide whether the study should be terminated pending the opinion of an independent expert. The adverse event will be considered at the next Committee meeting and a decision will be made on the need to change the information leaflet and/or study protocol.

On completion of the research you must submit a brief report (a maximum of two sides of A4) of your findings/concluding comments to the Committee, which includes in particular issues relating to the ethical implications of the research.

With best wishes for the research.

Yours sincerely

Professor John Foreman
Chair of the UCL Research Ethics Committee

Cc: Lucy Grayton & Phebe Burns

UCL Research Ethics Committee, c/o The Graduate School, North Cloisters, Wilkins Building
University College London Gower Street London WC1E 6BT
Tel: +44 (0)20 7679 7844 Fax: +44 (0)20 7679 7043
ethics@ucl.ac.uk
www.ucl.ac.uk/gradschool

28 March 2013

Professor Pasco Fearon
Research Department of Clinical, Educational & Health Psychology
University College London
Gower Street
London, WC1E 6BTL

NSPCC
Cruelty to children must stop. FULL STOP.

National Society for the Prevention of Cruelty to Children

Weston House
42 Curtain Road
London EC2A 3NH

Telephone: 020 7825 2500
Fax: 020 7825 2525
www.nspcc.org.uk

Dear Pasco,

Re: Application to the NSPCC Research Ethics Committee (REC)

Title of Project: *Minding the Baby: Challenges of Implementing a Reflective Functioning Parenting Programme*

Thank you for submitting your project to the Committee, and for coming in to talk to us. The Committee read your application with interest, and thought it addressed all the ethical issues thoughtfully and thoroughly.

The Committee raised the following points for you to consider:

- The Committee would like reassurance that the participants are given sufficient time between being given the Participant Information Sheet and providing consent that they are happy to take part. This could be achieved if the information was always sent or given out by practitioners in advance.
    - The Committee suggested it would be helpful for the practitioners to have a more detailed script for introducing the study and explaining what is involved.
    - The Committee suggested that the information sheet should state that the interview will contain questions regarding the participant's views/feelings about their worker, giving reassurance that any comments will remain confidential.
    - The Committee requests an increase to the font size on the Participant Information Sheet.
    - The language on the Participant Information Sheet is rather dense, so the Committee asked if you could consider revising it and making it more lay-friendly. Likewise could you simplify language on the consent form as this it currently too complex.
    - The Committee picked up some small typos in the Parent Information Sheet, so would recommend a thorough proof read before finalising.

The Committee approved the application **on the condition that the points raised above are addressed**. Please provide me with a written response on these, via Bernice Ash on [redacted] If you would like to discuss these comments in more detail, please contact me, again via Bernice.

Regards

Dr Nicholas Drey
Chair, NSPCC Research Ethics Committee

Appendix 3. Participant Information Sheet

Minding the Baby: The Challenges of Implementing a Reflective Functioning Parenting Programme

Participant Information Sheet for Staff

You will be given a copy of this information sheet.

We would like to invite you to take part in this study. Before you decide whether you want to take part it is important for you to know more about the study, what it involves and why we think it is important. We hope that the information below will help you to make your decision. Please ask us if there is anything you are unclear about or would like more information about.

What is the purpose of the study?

This study is being carried out by researchers at UCL, as part of a larger research project examining Minding the Baby (MTB) in the UK. We would like to find out about practitioners' and supervisors' experiences of delivering MTB, with a particular focus on the challenges of implementing the model and the challenges of engaging families. We are also asking families about their experiences of MTB. We hope that this study will help us to understand the challenges of delivering MTB, and therefore help to improve the way MTB is implemented and maximise the benefits to those receiving the programme.

Why have I been invited to take part?

You have been invited to take part in this study because you are either one of the practitioners currently delivering MTB or are supervising a practitioner who is delivering MTB.

What does taking part involve?

If you choose to take part in this study, a researcher will arrange a day and time to come to interview you. During the interview you will be asked about your experiences of MTB and the challenges you have faced whilst implementing the model. The interview will last approximately 1 to 2 hours. The interview will be audio-recorded to make sure that we do not miss anything which is said. The audio recordings will be transcribed and then wiped clear straight after transcription. You may withdraw your data from the project at any time up until it is transcribed for use in the final report.

It is possible that there will be some follow-up questions to the answers which you give during the interview. Any follow-up questions will be completed over the telephone.

Do I have to take part?

No. You are free to decide whether you wish to take part or not in this study and you can withdraw at any point. A decision to withdraw at any time, or a decision not to take part, will not affect your involvement with MTB or your employment with the NSPCC.

What are the risks and benefits of taking part?

It is not anticipated that taking part in this research will pose any risks to you or be uncomfortable in any way. However, if at any point you become concerned or do not wish to continue you may notify the researcher and the interview will be halted immediately.

What will happen to the information I provide?

The audio recording of your interview will be transcribed to help us to study all of the information that we have gathered from you and the people taking part in the research. The audio-recordings will be deleted straight after transcription. The analysis of this information will be carried out by the research team at UCL, with the aim of identifying the main themes and ideas expressed by people during their interviews. The results will be written up as part of a doctoral research project, which may be published in a scientific journal. In addition, the research will be written up in reports for the NSPCC. We hope that the findings of this study will also be useful in informing and improving the service that MTB provides.

Will my taking part in this study be kept confidential?

Anything that you say during the interview will be kept strictly confidential, except if you tell us something that raises concerns about your safely, the safely of someone else, or the safety of a child. If this happens we may have to break this confidentiality, but will aim to discuss any concerns with you prior to doing so.

All information will be collected and stored in accordance with Data Protection Act 1998. Audio recordings made during interviews will be password protected and destroyed once the contents have been written down. Names and any other information which could identify you will be removed from the transcribed versions of the audio recordings to ensure that you cannot be identified. We may include things that you said in the final report but we will not use any names and will make sure that the things you have said cannot be linked to you. We will store the written versions of the interview information, minus any names or other identifying information, in a secure location for up to 5 years. The things that you talk about during your interview will not be directly passed on (e.g. in a way where you can be identified) to your supervisors or managers.

Complaints

If you would like to complain about any aspect of the study, you can contact the lead researcher, Pasco Fearon (contact details below). Alternatively, the NSPCC has established a complaints procedure, and you can pass on a complaint to any NSPCC member of staff, volunteer, or local office. Alternatively, please email comments@nspcc.org.uk or call **020 7825 2775**, You can then ask to speak to [redacted] and inform them that the name of the project is: ***Minding the Baby: The Challenges of Implementing a Reflective Functioning Parenting Program.*** Further details of our complaints procedures can be found here: http://www.nspcc.org.uk/help-and-advice/enquiries/frequently-asked-questions_wda83770.html#complaint.

Contacts

If you would like any further information or have any questions about this study please contact Lucy Grayton or Pasco Fearon:

Lucy Grayton, Trainee Clinical Psychologist - lucy.grayton.11@ucl.ac.uk
Professor Pasco Fearon, Professor of Clinical Psychology - p.fearon@ucl.ac.uk
Research Department of Clinical, Educational and Health Psychology, UCL

Thank-you for considering taking part in this study

This study has been approved by the UCL Research Ethics Committee (Project ID Number): 4380/001

All data will be collected and stored in accordance with the Data Protection Act 1998.

Appendix 4. Participant Consent Form

Minding the Baby: The Challenges of Implementing a Reflective Functioning Parenting Programme

Informed Consent Form

Please complete this form after you have read the Information Sheet and/or listened to someone tell you about the research.

Thank you for your interest in taking part in this research. Before you agree to take part, the person organising the research must explain the project to you. If you have any questions about what you have read in the Information Sheet or about what you have been told, please ask the researcher before you to decide whether you would like to take part in the study. You will be given a copy of this Consent Form to keep.

Participant's Statement

I: _____

- have read what is written above and in the Information Sheet, and I understand what taking part in the study involves
- understand that if I decide that I no longer wish to take part in this study, I can tell the researchers and withdraw immediately.
- agree to the use of my personal information (your name, address etc.) for the purposes of this research study
- understand that this information will be treated as strictly confidential and dealt with under the Data Protection Act 1998 (my information will be kept private and safe).
- agree that the research project (study) named above has been explained to me properly and I agree to take part in this study.
- Understand that what I say will be taped (which will be deleted straight after it is written down) and I agree that this information can be used as part of the study.
- agree to be contacted in the future by UCL researchers if they have more questions after the interview, or if they would like to ask me to take part in some further studies.
- understand that the information I have given will be made public as a report and/or in scientific journals. I understand that confidentiality (privacy) and anonymity (people not being able to work out who I am) will be kept

Signed:_____ Date: _____

This study has been approved by the UCL Research Ethics Committee (Project ID Number): 4380/001

Appendix 5. Interview Schedule

General challenges of implementing the model

How's the programme going?
Can you give me the headlines – what have the highs been and what have the lows/challenges been?

How has your practice changed?

The MTB program targets RF - is this different from what you were doing before you joined the program?

In what ways has it changed the way you practice?
prompt: Could you give me some examples of those changes? Could you give me examples about the way RF theory has changed the way you work? It what ways do you apply RF theory? How do you bring RF theory into practice?

prompt: Have there been any challenges to changing the way you practice? Has that been hard to change? Have there been positives to changing the way you practice? Are there things that made that transition harder? Are there things that made/could make that transition easier?

Has working on MTB had any effects on your identity as a professional or the way you view your role as a professional?
prompt: What have the implications of these changes been? (probe for pros and cons)

What have been the challenges of actually practically applying RF theory in the way you work with your families?
prompt: challenges of keeping the baby/mother in mind/working with high risk families
prompt: what have the implications of these challenges been? how have you worked with/overcome these challenges?

I understand that you work in pairs on MTB, how have you found that? Have there been any challenges? Have there been benefits?
prompt: how does working in pairs fit with RF theory? (further prompts: enquire about how joint working effects reflection, relationship with families, practical tasks, supervision)

Initial Engagement

Can you tell me about your experiences of engaging your families at the start of the programme?
prompt: what ingredients do you need for this to be successful?
prompt: how important is the early engagement?/what's the impact of the level of early engagement?
prompt: what role does RF theory play in engaging families?

What made if difficult/barriers to initial engagement/challenges to initial engagement?
prompt: barriers for mothers/wider family/other professionals or referrers? Are these barriers linked in anyway? Are these barriers specific to MTB/RF?
prompt: what were the implications of that? How did that affect the way you worked?
prompt: how did you overcome/work with those challenges? Are there things that you would change in the program to remove barriers to engagement?

In your experience, what improved early engagement?
prompt: what ingredients do you need to successfully engage families in MTB?
prompt: are there things in the model you would change to make engaging families easier?

Why do you think some families disengaged? Or why do you think some families chose not to engage?

How does RF theory relate to engaging families? Does RF theory come into the way you/the model engages families in the very early stages?

Maintaining relationships

Can you tell me a bit about your experiences of maintaining relationships with families?
prompt: what have been the challenges? What have been the barriers to maintaining relationships? What has made it harder to implement the model with your families? What role has supervision had in helping to overcome difficulties with relationships (RF?)

prompt: what's helped? What role has RF theory helped to do this? How does the MTB model help to overcome difficulties? What role has supervision had in helping to overcome difficulties with relationships (RF?)

What difference do you think your relationship makes to the work you do with families?
prompt: In what ways does it make a difference/is it important?
prompt: how does it make it easier to work/how does it make it harder to work?
prompt: How does this relate to RF? What other ingredients are needed to implement RF theory?

Is this way (MTB/RF) of engaging/reaching/building relationships with families different to how you've worked before?
prompt: In what ways is it different/the same? What elements are new/specific to MTB/RF?

Supervision

What's your experience of supervision on the programme?
prompt: It what ways is it useful? It what ways is it less useful?

What are the challenges of the model of supervision used within MTB?
prompt: different types, frequency, practicalities, multiple supervisors, joint supervision

In your view, what's the role of supervision?
prompt: what are the tasks of supervision?

Throughout our interview, you've mentioned some challenges of implementing the MTB framework (give examples from earlier in interview), what role does supervision play in helping overcome (and not overcome) those challenges?
prompt: reflective functioning/mentalisation, engagement, relationship building, chaos, practical issues, risk,
prompt: can you give me an example of that? Are there other things that would help overcome that in supervision?

In what ways does supervision help/not help with enabling engagement and relationship building with families?
prompt: How does this fit with RF? Does supervision specifically use RF theory to help with this? In what ways….

Can you tell me about your relationship with your supervisor(s)?

To what extent is RF theory is used in supervision/the way you are supervised?
prompt: is that helpful/unhelpful - in what ways? Would you like more/less RF theory in supervision?
prompt: do you feel held in mind by your supervisor?

PROMPTS THROUGHOUT THE INTERVIEW:

How have you managed to overcome that?
How do you resolve that? What would help to resolve that?
Do you have ideas about what would make that easier?

How does that fit with RF theory/the model?
Does RF/the model help to overcome that in any way?
Is that specific to working using RF theory?

Does that seem appropriate/helpful/necessary?
How does this impact on your work?
Does this have an impact on other areas of your work?

Can you tell me more about that?
Could you give me an example of that?
Could you be more specific?

Appendix 6. Illustrations of the stages of analysis

Example of the initial stage of analysis: annotations on the interview transcript of Participant 3

This excerpt follows on from the participant discussing her experiences of engaging the mothers. She had detailed the extent of the challenges faced, explaining that many of the women she worked with were very "avoidant" interpersonally, and would "shut-down" when trying to encourage them to reflect on their thoughts and feelings.

P3	*We had another young mum, and she's very young, and oh gosh, she was really avoidant, she had been really avoidant. , She was young and there had been lots of things going on in her life, and we stuck with her. But what worked with her, this was incredible actually, what worked with her we'd go and see her at home, and she never spoke, she never really said anything - trying to use any just general conversation with her, you didn't get anywhere. And one day we took her out, we were trying a different tack, and we said "lets take her out, lets meet her in a coffee shop." Four hours later myself and [paired practitioner] were sitting there thinking "we need to go", our ears were burning! This girl never stopped!*	**Sticking with Mums despite avoidance** **Communication skills are poor** **Impact of environment on Mums is huge = communication and ability to open up**
IV	***And what do you think made that difference?***	
P3	*The difference was that we hadn't known that the environment she was living, the home environment was difficult, really difficult for her, and she didn't have any, she had a whole lot of pressures within the home. She's a young mum who lives at home with her mum and her siblings, and all sorts of stuff. And she very much had the caring role within all of that. She never had her own space to speak. And we just thought she was incredibly quiet, her social worker said this wee girl never speaks at all. So the shock, the absolute shock, we couldn't get rid of her, hours later, and she talked about, oh gosh, from her, everything, in terms of her own past and experiences, her baby. And what shocked us, was that we were amazed with this girls ability, her insight was, she was only 14, and her insight into the baby, her insight into what's been going on in her life, and her own, just generally her ability to just reflect. And she's been, she's been absolutely brilliant, this wee girl. And that was the absolute turning point for this one, because it took months and months you know, she wouldn't be in for our visits, and if she was in she wouldn't speak, and when we took her out it was just like a completely different person.*	**Family pressures** **Never had opportunity to speak = new experience = different experience of mum compared to other professionals** **Impact of environment → Mum's RF capacity** **Importance of persevering - not giving up?**

Example of the second stage of analysis: clustering the data into tentative themes across the transcript of Participant 3

This participant spoke at length about the impact the home environment can have on mothers. The following is an excerpt from the summary document constructed for this participant, in which all of the key ideas and themes discussed during her interview were collated.

Environment - " I hadn't appreciated how much the environment affects things…"

Environment can be oppressive - neglected, filthy, dark, dirty, depressing

Practitioner feels horrible there, no one feels comfortable

"And I felt horrible in the sense, do you sit down in here? It was just awful. And it wasn't somewhere I would want to sit -I can't imagine the mum would have been happy, having to be in there"

"And I don't feel comfortable in it, and I guess they don't feel comfortable in it either, because it's not a nice environment to be in"

"It's hard to kind of have many feelings beyond depression when you're there, it's pretty horrible"

Environment can have a significant impact on mothers' presentation

"And one day we took her out, we were trying a different tack, and we said "lets take her out, lets meet her in a coffee shop." Four hours later myself and [paired practitioner] were sitting there thinking "we need to go", our ears were burning! This girl never stopped!

"…and I certainly feel that shows in the parents, they feel a lot more comfortable in their home environment as well. I think they're more relaxed, a lot more relaxed, in their communication style…"

Environment can have a significant impact on mothers' RF capabilities – more able to relate to others and think about baby

"And what shocked us, was that we were amazed with this girls ability…her insight into the baby, her insight into what's been going on in her life, and her own, just generally her ability to just reflect"

Environment mirrors mothers' minds – hard to feel anything other than depressed when you're there – *have to shut mind off to avoid the horribleness*

"It's just like a dullness in the home, that really mirrors their mind, in terms of being dull, and shut down...you know…it's really depressing"

"And what, her presentation is really symbolic of her mood as well, in terms of when she says she is feeling depressed, and the kind of house, and the environment, and the difference when she's out, it terms of just her general mood is just totally different"

Practical difficulties – "there is nowhere to put the baby down to do this work, or even just for the mums to sit…it's really not conducive to doing the work, within these homes"

Example of the later stages of analysis: clustering the data into tentative themes across the set of interview transcripts

Under the domain of 'Relationships are Key', giving mothers a different relational experience was highlighted as being very important. Across the transcripts, quotes and key ideas were collated under different theme labels. A selection of the quotes collated under two of the theme labels is presented below.

They feel valued and cared for – MTP practitioners are interested in them and their thoughts and feelings, this leads mums to feel cared for and valued.

"I guess it makes them feel like someone's got time. You're not rushing; you're not like on a conveyor belt. You're just someone that actually wants to come and spend half a day with them…they feel like we care about them rather than just some other professional coming in, visiting them and observing them. They actually feel like we're interested and we care about them..." [Practitioner 1]

"I think for the first time it gives a lot of these mums an opportunity to say how they're feeling. And it's very different from every other profession that's gone into them. A lot of times they're not asked... They're asked about their post-natal questionnaire, and health assessment, the health-visitor will do that part and identify whether the person has depression or if there are additional needs within that family unit. But they don't have the time! And it feels, for us, it feels like a very privileged position." [Practitioner 4]

"I think for a lot of young people it's different to be asked what they think about something and how that makes them feel. I think for a lot of people that don't have a lot of experience of being asked that. Or feel anybody else is interested in how they feel, what they think of it sometimes. So I think for some people that really does help, engagement, you know, and they think she is interested in what I think about this." [Practitioner 8]

"I think a lot of people had the worry or concern that you were coming to their house and tell them what to do, you know [because that's what they're used to]. I think when they see just a normal person that would just sit and chat with them and listen to them and ask their opinion, or ask what their experience was" [Practitioner 8]

"…and I think if you can just go in and be sort of like, I've really missed you, where have you been, what have you been up to, and I think it just lets them know that you're there because you want to be and you're just interested in them" [Practitioner 9]

"You keep coming back" – not getting put off when others would, being persistent, and consistently being there for them.

"So I think when you realise actually you'll do what you say you will and you keep coming back and you keep your appointments. And I think also if they disengage for a little while, if you make it easy for them to, you know, to sort of reengage, that seems to make it easier, you know, when they know that you're not going to get angry with them, or tell them off, or something like that, you know. And I think when they can see that you're being flexible and considering their needs. That really helps" [Practitioner 8]

"…one of the Mums…who was really avoiding everybody, and didn't engage with any services, [said to us] that was the one thing that she appreciated, that we kept coming back, we kept turning up, and we didn't give up on her, you know. So I think there is…a bit of comfort in that sometimes to know that somebody is still going to be thinking about you, you know" [Practitioner 8]

"I know anyone else would have given up and thought that she didn't want the programme, but with her we got such a strong sense that she wanted us" [Practitioner 1]

"And she knows that we come back, every week, we always come back, we've been seeing her since last summer and she knows that we're always there, we come back, we never miss a visit." [Practitioner 1]