Therapy Experience of Parent-Infant Psychotherapy for mothers and their infants

Literature Review

Empirical Research Project

Reflective Commentary

Candidate number: HJCW9

UCL

Submitted in partial requirement for the Doctorate in Independent Child & Adolescent Psychotherapy

(Independent Psychoanalytic Child & Adolescent Psychotherapy Association and The Anna Freud National Centre for Children and Families)

DECLARATION

I declare that the material submitted for examination is my own work. The ideas and findings of others have been referenced in accordance with the guidelines provided and any work by others has been acknowledged.

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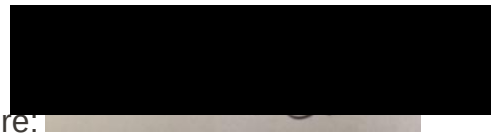
Date: 25 March 2019

Signature: 

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Abstract

This study explores mothers' experiences of parent-infant psychotherapy (PIP) with their babies in the first year. **Literature review.** The literature review examines existing studies to define and understand therapy experience for parents and their children. The existing literature highlights the complex dynamics of this form of research, and informs the subsequent empirical study. **Empirical study.** The empirical study is a thematic analysis conducted on interviews of mothers in PIP as participants of a recent RCT. The aim was to understand what PIP is like for mothers and their babies. The results reveal themes that summarise the complexity of mothers' description of experiences in this relational-based therapy. Although methodological limitations are considered, the findings still contribute an understanding of the experience of PIP in the first year for mothers and their babies. **Reflective Commentary.** The reflective commentary summarises the process and experience of conducting this dissertation as a combined clinical doctorate in child and adolescent psychotherapy.

Impact Statement

Impacting PIP

Attachment models have been shown to impact all human relationships. Early interventions like relation-based parent-infant psychotherapy (PIP) address pathologies between parents and their young children. The current study developed in part to understand why results from a recent RCT showed that mothers in PIP appeared to improve in their overall well-being, but that parent-infant interactions and child outcomes showed no change. However, early interventions in the perinatal period have been shown to impact on child development so it seemed important to understand something of these findings. Taking account of therapy experience was identified as an avenue for looking at the treatment from the mothers' perspective.

Impacting Service Users

The accounts of mothers in PIP offered insight into what therapy was like for them and perhaps inform others looking into this form of psychotherapy. For instance the unknown at the beginning of treatment caused much anxiety for most of the mothers. Furthermore, themes indicated parallels to pre-existing literature, highlighting that although a small, qualitative piece of work, there was the possibility for generalisation across to different therapies. If clinicians and researchers take note, this sort of study may further impact the development and delivery of psychotherapy in mental health services, and in turn improve efficacy.

Service Users Impacting Practice

As initiatives such as IAPT continue to measure efficacy of mental health services, accounting for the views of services users is considered vital for outcomes. Therapy experiences must be considered. In light of this particular study the rich accounts should inform clinical practice and empirical research. For instance, in terms of methodology the structure of interview schedules may need to be considered in how it accounts for the therapeutic relationship for parent(s) and infant. Furthermore, first-hand accounts might offer the opportunity to learn what techniques to adapt to meet individual needs of service-users. Therefore, it is also crucial that the reporting of findings be clearly outlined and available to clinical practitioners. Therapists might then contribute their own invaluable perspective as field experts. In the current study and search of existing literature it appears increasingly important to promote new dialogue between empirical and clinical practitioners.

Provoking New Dialogue

Dialogue is championed, but discrepancies appear in the definition of therapy experience. Since therapy experience is known to influence outcomes, this may be one area for further dialogue amongst clinicians, researchers and service users alike. There may also be call for examining how and what is consistently investigated as the field hopefully further dissects core methodological components. Within the context of a larger study, additional qualitative investigations such as this one, might prove their worth, particularly in understanding quantitative results.

Furthermore, it is assumed that the aim of all of these studies is to improve the quality of care for families supported by mental health services and therapies.

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Part 1: Literature Review

Title: Literature Review of Therapy Experience for Parents and Young Children

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Abstract

This is a literature review of the experience of psychotherapies for parents and young children. This review draws upon studies that might inform relational based therapies in the postnatal period. The aim was to gain insight into what constitutes therapy experience; how this type of research might be used to inform clinical and empirical practice for relational based therapies; and whether the experience of therapy influences outcomes for parents and their children. From discussion of existing studies emergent themes include: relevance of therapy experience and patient feedback; the therapeutic relationship and key therapist traits; informing the setting and professional constancy; expectations and outcomes and therapy experience; culture and diversity; therapy in the context of a clinical trial. The findings identified methodological complexities for this area of research, and limitations to generalisation. Although current evidence appeared to be based on data from adult and individual therapies, the review concludes that therapy experience has been shown to impact on outcomes in various psychotherapies. Therefore, as an underdeveloped gap therapy experience for parents in relational based therapies needs understanding further investigation.

Introduction

Gathering existing literature of therapy experience for parents and children is the focus of this review. Although attention is paid to the wider body of evidence of therapy experience, current literature may inform relational based therapies in the postnatal period. The aim of this review is to inform current understanding of what constitutes therapy experience, what influences it, and how it might apply to relational based therapies in the postnatal period for parents and their infants. Barlow and colleagues (2015) review the effectiveness of parent-infant psychotherapy, and outline the quality of the parent-infant relationship as crucial for a range of developmental outcomes in the child. Several factors are found to impinge upon the parent-infant relationship such as maternal depression, socio-economic stressors, trauma, and/or difficulties in the mother's own attachment history.

Parent-infant psychotherapy (PIP) is an intervention model that treats the relationship between parents and their infants. Though it is understood to be beneficial, we do not know a lot about how parents' experience this treatment model. The literature in this review highlights the relevance of patient feedback; the therapeutic relationship and key therapist traits; professional constancy and informing the setting; expectations and outcomes of therapy experience; culture and diversity; therapy in the context of a clinical trial. The themes emerged within and across the literature to build a picture around the complexity of extrapolating therapy experience, and the research that attempts to understand it. The review identified the importance of

considering feedback to highlight outcomes and overall experience; the complexities of conducting a review of literature across different interventions; and limitations to this qualitative research based on specific modes of treatment. This is all discussed within the context of benefitting parents and their children in relational based therapies in the first year.

Psychoanalytic parent-infant psychotherapy

Over the past two decades in the field of mental health there has been a greater focus on early intervention services with the aim of preventing future disturbances (Fonagy, 1998; Kassebaum, 1994; Zigler & Styfco, 1995). It is acknowledged that such interventions alleviate emotional and behavioural difficulties in order to protect or improve child outcomes (Fonagy, et al, 2015; Kennedy & Midgley, 2007; Nylen, et al, 2006). Relational-based therapies during the perinatal period often attend to parenting, caregiving and attachment patterns for mother and infant (Nylen, et al, 2006; Baradon et al., 2005; Fraiberg, et al, 1975; Lieberman & Pawl, 1991; Knoche et al., 2012; Sanders, et al, 2014; van IJzendoorn, et al, 1995). Risk and protective factors outside the mother-infant relationship might indicate that the efficacy and effectiveness of interventions must account for contextual factors (Baradon, et al, 2005; Fonagy, et al, 2008; Weiss, et al, 2000). However, change in maternal mental health is considered crucial to the improvement of life for both mother and child (Fonagy & Bateman, 2006; Fonagy, et al, 2015). Guedeney and colleagues (2014) describe an array of mother-infant relationship-based psychotherapies and the impact that these can have on outcomes for both mother and baby where the mother is depressed

and there is concern about attachment patterns. This study emphasised this work being as important as adult psychiatric treatments for depressed mothers.

The model of PIP investigated in this study is described by Baradon and colleagues (2016) as a relational-based intervention with parent(s) and infant in the room with the therapist. The basis of the intervention is an understanding that parents are impacted both by the direct experience with the new baby, and their own experience of being parented. The central aim is to address the parent-infant relationship by encouraging reflection on the meaning behind both baby's and mother's actions. It is a complex task for the therapist to be able to pick up on the non-verbal communications, otherwise known as the transference, that may indicate painful feelings, that then need care in addressing (Freud, S, 1914; Winnicott, 1956). A meta-analysis by Barlow and colleagues (2015) found that relation-based therapies during the perinatal period can improve outcomes for mothers and infants because of the focus on this relationship. Waters and colleagues (2000) also demonstrated that the skill of the PIP therapist to take account of the individual and relational needs can potentially address attachment behaviour.

A recent Randomised Control Trial (RCT) of PIP (Fonagy, et al, 2015) aimed to determine whether the model of PIP could improve infant outcomes and mothers' mental health. Positive change was determined for the PIP treated mother-infant dyads relative to control on overall maternal mental health; mothers' emotional well-being; maternal representations; and parenting stress. Whilst maternal outcomes

generally improved for the PIP group relative to the control group, little to no change was found for infant outcomes including development and attachment patterns; parent-infant interactions and maternal reflective functioning.

Despite maternal mental health difficulties, PIP may be considered a crucial step in the improvement of life for both mother and child (Fonagy & Bateman, 2006; Fonagy, et al, 2015). Salomonsson and Barimani (2017) qualitatively explored 10 mothers' experiences of mother-infant psychotherapy (MIP) producing two main themes of the therapy addressing the transition to motherhood and relationships with them infant and family. They found that the treatment did go some way to addressing relationships, infant and mother needs. However, mothers did not feel enough focus was paid to their needs. The MIP treatment is based more on therapist-infant interactions, sort of a modelling of how to make sense of the infant's affect and symptoms. Although there is overlap, MIP is qualitatively different from PIP which treats the *relationship* between mother and baby as the "patient". (Baradon, 2016; Salomonsson & Barimani, 2017). MIP may differ in technique, but the study concluded that investigating the experience of the mothers clarified disparity in outcomes for mothers and their babies who receive therapeutic input in the perinatal period.

Disruptions in the early parent-infant relationship

The quality of early parent-infant attachment relationships predicts a multitude of outcomes (Barker et al, 2012; Brennan, et al,

2000; Cox, Murray & Chapman, 1993; Field, 2010; Goodman, et al, 2011; Oates, 2003; Gress-Smith, et al, 2012; Liberto, 2012; Teti, et al, 1995; Murray & Cooper, 1997). There are a number of factors that may impinge upon these relationships. These include maternal depression, socioeconomic stress, attachment difficulties and trauma. These may lead to a need for therapeutic intervention.

Depression. Maternal Depression has been shown to impact 10-15% of mothers (Savage-McGlynn, E et al, 2015). Maternal psychopathology may impact the quality of mother-infant attachment (Brennan, Hammen, Katz, & Le Brocque, 2002; Hammen & Brennan, 2001; Hipwell, et al, 2000; Lewinsohn, Olino, & Klein, 2005; Miller, Warner, Wickramaratne, & Weissman, 1999; Teti et al, 1995). The timing, severity and chronicity of depression in the mother also impacts the behaviour of the infant (Brennan et al, 2000). Children of depressed mothers can be at greater risk in their emotional and cognitive development (Cohn, et al, 1986). Depression can also impact a mother's capacity to be attuned to her infant and the quality of the parent-infant interaction (Barker et al, 2012; Brennan, et al, 2000; Kim-Cohen et al, 2005; Lyons-Ruth, 2008; Murray & Cooper, 1997; Murray, et al, 1996; Savage-McGlynn et al. 2015; Schore, 2002; Sroufe, 2005;). Recurrence is associated with worse outcomes for children (Frye & Garber, 2005; Murray, Woolgar, Cooper, & Hipwell, 2001; Shaw et al., 2006; Silk, Shaw, Skuban, Oland, & Kovacs, 2006; Spence, Najman, Bor, O'Callaghan, & Williams, 2002). Negative outcomes for children have been linked to criticism, unresponsiveness and unsupportiveness exhibited by and

toward parents concurrently experiencing depression (Cicchetti, Rogosch, & Toth, 1998; Garstein & Fagot, 2003; Marmostein & Iacono, 2004; Milgrom, Westley, & Gemmill, 2004; Murray et al., 2006; Nelson, Hammen, Brennan, & Ullman, 2003). The psychoanalytic findings, corroborated by empirical research in neuroscience (Schore, 2002) and attachment theory (Ainsworth, et al, 1978; Bowlby, 1969; Sroufe, 2005), illustrate the ways in which early developmental disturbances can be linked to later psychopathology, and that this in turn adversely effects the development of the next generation of children.

Socioeconomic adversity. Further stress factors create a cumulative effect, and disadvantage the mother and child (Barker, et al, 2012; Brennan, et al, 2000; Cohn, et al, 1986; Murray & Cooper, 1997; Stein, et al, 2008; Teti, et al, 1995). Contextual factors, such as socioeconomic standing, have been found to be in concurrence with the onset or recurrence of depression (Barker, et al, 2012; Chicchetti, et al, 1998; Ashman et al, 2008; Dawson, et al, 1993). Thomson (1994) highlighted that socioeconomic variables such as education and parental structure particularly influence a child's emotional development. There are many factors that impact a new mother, and economic resources may play a role in how she manages the challenges of mothering, and may influence therapy engagement if it is needed (Thomson, 1994).

Trauma and attachment. Traumatic events such as the death of a loved one, miscarriage, abuse and neglect represent adversity for both mother and infant (Cassidy, et al, 2001). When a trauma is left unresolved for the parent this often results in a disorganised attachment

within the infant (Hughes, et al 2006; Kenneth, et al, 2006; George and Solomon, 1996; Teti, et al, 1995). The impact can differ from one child to the next, and can be managed differently depending on the age, developmental stage, and external support for the mother and child (Hughes et al, 2006; Main & Hesse, 1990). Impingement upon the mother's delicate state of mind can feel catastrophic and leave the infant vulnerable (Bowlby, 1960; Bowlby, 1969). This joint state between mother and infant threatens survival for infant and/or mother.

Negative life events are important factors for attachment classifications (Ainsworth, et al, 1978; Waters et al, 2000). It has been suggested that previous experience of attachment in the parent might influence response to trauma (Cassidy & Mohr, 2001). Attachment behaviours during traumatic experiences are highly activated and utilised when there is a threat to infant development (Bowlby, 1969). The attachment pattern may become disrupted if a mother or parent induces ongoing stress, or an infant stimulates stress for the vulnerable mother (Ainsworth, 1978; Main & Hesse, 1990). Attachment patterns during negative life events require both mother and infant to develop necessary defence mechanisms for coping, that may become maladaptive in the long-term (Bowlby, 1969; Ainsworth et al, 1978; Cassidy &Mohr, 2001; Main & Solomon, 1986; Main & Hesse, 1990). It has been suggested that increasing the mothers' attunement to her baby and belief in their ability to parent may improve maternal emotional and mental health and thereby the well-being of the infant (Cassidy and Mohr, 2001; Fonagy & Target, 2005; Winnicott, 1960).

Parent-infant dyads impacted by any or all of these impingements may then need interventions. Many treatments tend either to target depressive symptoms or parenting practices (Bailie, 2012). A longitudinal study of these therapies for mothers diagnosed with post-natal depression found that these interventions had only short-term benefits on early relationship difficulties (Murray et al., 2003). Where researchers have measured concurrent parental depression, they have found that it is associated with poorer engagement with, and response to, behavioural parent training (Baydar, et al, 2003; Reid, Webster-Stratton, & Hammond, 2003). Therefore, further understanding is needed to understand how to engage these vulnerable parents and their infants, and nurture a positive therapy experience and outcomes.

Therapy experience

"Therapy experience" is defined here as a reflective account of the physical and emotional experience for a person engaged with a therapist in a therapeutic treatment. This investigative research attempts to deduce the personal experience of treatment for patients and inform therapeutic technique (Schrachter, 1990; Schrachter, et. al., 1997). It was concluded in Elliot and colleagues' (1989) meta-analysis that it can be difficult to apply findings due to the variety of methods and measures, and the array of therapies. Furthermore, this type of research has been viewed with suspicion, due to biases around the validity and accuracy of patient accounts (Strupp, 1996). However, Midgley and Target (2005) argued that such accounts prove accurate as the remembered and felt experiences that have persisted over time, and provide an important

description of patient feedback. This could be argued as ever relevant to the efficacy of mental health services.

There is considerable debate about methodology. Some research directed on measures used to collect service user feedback within Services has shown the relevance of gathering this data in relation to therapy outcomes (IAPT, 2011; Wolpert et al, 2016). Gallegos (2005) conducted a qualitative study of nine adult psychotherapy patients and their experiences of individual psychotherapy. The findings suggest that although there was symptom relief post therapy, there were limitations to patient feedback via questionnaires. This was argued due to the complex nature of the therapy process. Although an investigation into therapy experience, it was observed that what is asked may not be what is important to the client, but something that the researcher wants to know. Therefore, differentiation of the aims of the therapy from the research may clarify clients' understanding of the parallel tasks. Schachter and colleagues (1997) postulated that post-termination contact poses an opportunity for stabilisation of gains made from therapeutic work. However, that study argued evaluation of technical assumptions made by clinicians in therapeutic decisions might then influence experience, and therefore outcomes, depending on how and when they are made. However, there still appeared to be conflict between intervention and research.

Knowles and colleagues (2014) reviewed the personalisation of therapies in computerised therapy for depression and anxiety. The study emphasised the challenge to professionals to cater treatment to the

individual needs of patients, yet maintaining the integrity of their theoretical grounding. This emphasises the individual in treatment, and how a programme might be developed accordingly, whilst maintaining a professional standard across a cohort, such as parents and their children. This sort of feedback may also lead to useful implications for professional development.

The relevance of therapy experience and patient feedback

There has been interest in patient experience as increasingly depleted and overstretched mental health services attempt to effectively meet the needs of service users (IAPT, 2011). The meta-analysis by Levitt and colleagues (2016) linked treatment effectiveness to therapeutic experiences of clients. The client therefore holds rich information about what it is like to be in therapy and what is helpful, or unhelpful, in the process. Retrospective studies of experience evidence that reflections are well intact when investigated, and emphasise the value in using these accounts (Midgley & Target, 2005; Rennie, 1994).

Mental health services are under increasing pressure to deliver effective treatment, and organisations like the Child Outcomes Research Consortium (CORC; Wolpert et al, 2016) report that service users' experiences relate to outcomes. Some components that have been shown to influence the therapy experience (and therefore outcomes) include the therapeutic alliance. This is defined here as the establishment of the transference relationship between client and therapist; the capacity of the therapist to adjust and make use of different technique to evoke

the client's interest in seeking change; the level and sense of empathy the client feels coming from the therapist; clients' expectations of therapy and therapist; and openly addressing and thinking about cultural differences and experiences (Levitt et al, 2016; Strupp et al, 1964; Elliot et al, 1989; Poulsen et al, 2010; Strupp, 1964). Identifying areas of change, as a result of psychotherapy experience, contributes to an understanding of what patients find most significant, and inform future professional practice. A meta-analysis of patients' experience of adult psychotherapy (Levitt et al., 2016) emphasises the patient's role in directing professional practice of psychotherapists, which promotes patient-therapist relationship. The existing literature focuses on various psychotherapies, but there is little published evidence for the experience of parents in relational therapy such as PIP.

O'Connor and colleagues (1997) investigated the experience of 8 families' experiences of a narrative therapy, and the accounts emphasised empowering the client to reduce symptoms. Clients reported specific benefits such as "feeling empowered" and "being listened to" as important components of the therapy experience. Picking apart *why,* is complex. Knowles and colleagues (2014) reviewed qualitative studies of user experience of computerised therapy for depression and anxiety and found the personalisation of therapies to the individual to be of importance. Although this is specifically about computerised therapies, this conclusion considers the complexities of evolving generalised theoretical treatment and the challenge for professionals in then delivering it to the individual patients. This contributes to the argument

for conducting studies of therapy experience for the benefit of the individual in treatment, but also how a programme of treatment might be developed for the needs of a population like depressed mothers with infants in the first year after birth.

There is some suggestion that session-by-session monitoring and feeding back to prevent treatment failure, defined as individuals who do not benefit or worsen upon leaving treatment, is an important component of successful therapy (Lambert, 2010). The argument is that practitioners then learn when and how to intervene for those at risk of dropping-out, or not getting well enough. Routine outcome measures can be a tool to support this and previous patients' accounts might inform future practice. However, studies like that by Gallegos (2005) highlight limitations of these quantitative methods of measuring patient experience. Though useful for retrieving feedback on what might work in treatment, and measure change, quantitative studies ask specific questions and may not account for the dynamic experience particularly in the therapist-patient relationship (Gallegos, 2005). This qualitative data, though, has historically been considered subjective and therefore unreliable. Levitt and colleagues (2005) call for outcome measures that better reflect the patient experience that also reflects the diversity in traditions of psychotherapy.

Lewellyn and Hume (1979) emphasise the challenges in attempting meta-analyses of studies on therapy experience, particularly in the capacity to generalise from one study to the other. The complications of enquiring into, and including, clients' perspectives in

intervention development I suggested as having the potential to cloud professional judgement around best clinical practice. However, Levitt and colleagues (2016) examined contemporary literature base for adults' experiences of psychotherapy and argue that interventions informed by patients heightened therapists' understanding of clients in order to better recognise agents of change, and therefore expanding therapists' sensitivity to clients' experiences. There is therefore the suggestion that a therapist might intentionally adjust technique to shape the treatment accordingly, whatever the theoretical stance of the therapist. The sensitivity of therapist to patient in the transference might also be attributed to the nature of the relationship at the core of the treatment experience.

The therapeutic relationship and the transference

Psychoanalysts theoretically understand the establishment of the therapeutic alliance is based on the transference experience. This technical skill of the analyst is an attempt to make sense of the verbal and non-verbal communications, known as projections between therapist and patient (Freud, S, 1914). The meta-analysis by Levitt and colleagues (2005) on therapy experience for individual adult therapies identified that relational factors between client and therapist such as therapeutic alliance must be upheld in the process of therapy. Levitt and colleagues (2016) found that clients' sense of collaboration in the set-up, direction and ending of treatment within the therapeutic relationship is at the core of the therapy experience.

Furthermore, Fisher and colleagues (2016) conducted a study of 202 adults engaged in psychodynamic psychotherapy and found that the emotional experience of the therapeutic alliance strength indirectly predicted clients' level of functioning. This study emphasised the establishment of the therapeutic alliance so that the client might engage and benefit from the intervention, but does not suggest or recommend what might improve this. In the relational based treatment of PIP, the therapeutic alliance, or the transference relationship, between therapist and mother is indicated as an important component for outcomes (Baradon, et al, 2005; Barlow, et al, 2016). Lyons-Ruth and colleagues (2009) contribute with focus groups of therapists to examine potential factors of change in mother-infant psychotherapy. The findings highlight change as attributed to a positive relational development in the mother-infant dyad, established via a strong therapeutic alliance with the therapist. The construction of triadic relationship appears to be based on a therapists' capacity receive powerful projections from both mother and baby. Then, the therapist picking up the emotional experience in the transference may then be able to digest and process what is being communicated in order to help mothers and their babies feel understood.

Identifying how to establish a therapeutic alliance is complex. Llewellyn and Hume (1979) found that for adult psychotherapy this alliance is facilitated partly by clients' curiosity about themselves; an interest in why therapy is needed; engagement in and adherence to the therapy. The therapist must have flexibility in technique and be attuned to individual needs and demands. Simultaneously the therapist must

apply the appropriate theoretical and professional input (Llewellyn and Hume, 1979; Levitt, et al 2016). The “empathic therapist” was linked to treatment outcomes by Levitt and colleagues (2016). Empathy was defined as giving the client a sense that they were being understood, and fostered better engagement in the treatment. Picking up on the emotional experience in the therapy room has been credited with instilling a sense of safety for the client, leading to the lowering of defences therefore cultivating a greater capacity to explore vulnerabilities and anxieties (Levitt, et al, 2016; Winnicott, 1956).

Sheridan and colleagues (2010) studied therapy experience of the parents of adolescents undergoing family therapy and found that therapeutic experience was defined It is argued that by previous experience. The study explored why, and when, parents sought support after pursuing other resources. Over time, once they chose family therapy, if the therapist was found reassuring of their concerns, therapy could become a safe place. Other studies have contributed that identifying key anxieties in the transference can clarify reasons for needing therapy, and offer an agreed understanding of the aims of treatment if taken up by the therapist (Kertes, et al, 2009; Sheridan, et al, 2010; Westra, et al, 2010). The caring and competent therapist tending to the internal world of the patient, combined with a supportive and collaborative environment be the key to good outcomes (Kuehl, et al, 1990).

Peeler and colleagues (2015) investigated parents and nurses in a perinatal unit. It was concluded that nurses often focused on child well-

being at the expense of the frightened, vulnerable parents. The study concluded that parents' fear of the potential death of the child lead to a resentful dependence on professionals care directed toward the health and safety of the baby. This study argued for a shift in the care emphasising attunement with the families. The need for therapists to be in tune with clients' needs, to be able to read the transference communications, has been documented in other studies (Llewellyn & Hume, 1979; Kertes, et al., 2009; Westra, et al., 2010)

Kertes and colleagues (2009) found in their study on CBT that effective therapists focussed on collaboration with the client, rather than becoming directive toward or compliant with the patient. This contributes to Westra and colleagues' (2010) findings on expectations, which linked a collaborative therapeutic relationship with positive experiences. This study explored violations to therapy expectations over the course of 18 CBT cases. Violations were defined as moments when the therapy did or did not meet expectations, which then impacted process and outcome. Those who reported gains from therapy found a collaborative relationship with the therapist, particularly in setting and re-setting the direction of therapy. The most positive outcomes were reportedly those with an established sense of trust with their therapists. Trust was necessary for challenges to be safely made within a therapy session. Llewellyn and Hume (1979) emphasised the role of the therapeutic alliance in successful treatment. Westra and colleagues (2009) stressed the role of trust in the compassionate and collaborative therapist (Kertes, et al, 2009; Westra, et al, 2011). These findings contribute to the general

conclusion that the therapeutic alliance across modalities addressed expectations and biases that influence engagement and retention of clients. However, it is difficult to conclude whether such findings were purely a result of the therapeutic relationship.

Professional constancy and informing the setting

Professional Constancy. Professional constancy in this review is defined as the level of professional adherence to theoretical models of therapy. Cowdrey and Waller (2015) investigated the treatment for 157 patients with eating disorders and highlighted that deviations from evidence-based CBT impacted diagnosis and effective treatment. There appeared to be something important about clinicians' capacity to comply with the theoretical grounding of specific therapies, but simultaneously sensitively address the client's difficulties for which they have been referred.

Another study by Delsignore (2008) on group therapy argued that previous experience might impact the effectiveness of subsequent therapies. It was found that clients' perceived understanding of therapy or other professional interventions influenced whether current treatment was experienced as helpful. A positive experience could improve outcomes, but could also leave a client disappointed if it is not what was expected. A negative previous experience of therapy was more likely to lead to negative outcomes, but could also lead to an unexpected success. The findings about professional constancy seem to be a component of therapy experience that supports the needs for joint

understanding before the start of therapy, how it might be different from other therapies and agreement with the client on what it is they think they are in therapy for. Furthermore, the therapist should also take account of the specific presentation and traits of the patient.

Reasons for referral. Referrals for psychotherapy are made for a wide range of reasons and making sense of why and how they come through is a component of the therapeutic relationship. Weitkamp and colleagues (2017) investigated adolescents referred to a psychodynamic psychotherapy and explored non-engagement to produce themes that highlighted the role of the therapist in fostering realistic treatment and outcome expectations. The findings suggested making a successful attempt at treatment was important to consider the young person's own views and establish a collaborative relationship, put the patient at the centre of treatment, and therefore a sense of ownership over it (Weitkamp, et al, 2016; Weitkamp et al, 2017). Some patients wanted better access to information and understanding of the professionals' thinking from the point of referral (Kapur, et al, 2014). Kapur and colleagues (2014) studied a population of adolescents who hear voices found that young people wanted to feel listened to and heard by professionals. The population was treated by a particular intervention, but possibly it wasn't the intervention itself that was important. The sense that needs felt genuinely heard was vital. For participants to feel heard the therapist needed to engage with treatment delivery, whilst remaining in touch with why the patient feels he is attending. Therefore, the referral and pre-treatment preparation are of importance, but Kapur and

colleagues (2014) suggest it is discussion and thinking with the patient that establishes a positive alliance.

Saunders (1996) reported the importance of support outside the therapy - either from social services or within the family network. This study identified that social support is important throughout treatment and in particular in seeking of help, when they sought help and how much participants benefit from help on offer when they had ongoing support outside the therapy.

Informing the setting. Barros and colleagues (2008) looked at seven parents' experience of parent toddler groups and found that the setting, attendance and the toddlers' experience of the group important factors. These views were considered important in the evaluation of the intervention. Oetzel and Scherer (2003) argue for the therapist catering to the client, specifically in their cohort of adolescents. The study argued for the establishment of the therapeutic alliance that the researchers defined as therapists' capacity to generate a sense of empathy and genuine interest in the client. The therapist would then adjust technique to the presenting developmental stage. Finally, offering choice in the therapy can often provide the client with a sense of empowerment.

Peckett and colleagues (2016) explored fifteen mothers' experiences of implementing Lego Therapy at home for their children with autism. Participants reported that including the whole family improved at-home relationships by providing a space for parental collaboration within the process. This study highlighted that supporting the family around a

vulnerable mother-child dyad could improve relationships outside the therapy. Furthermore, it is concluded that this inclusion of families might have implications for engagement with services.

Culture and Diversity

The individual that comes to the therapy must be considered by the therapist. A meta-analysis by Levitt and colleagues (2005) references cultural difference impacting on the therapeutic relationship. A therapist addressing these factors openly and directly was shown to impact effectiveness, and clients' perception of a positive experience. Not addressing such difficulties might confound progress (Levitt, et al, 2016; Maat 1997). Differences in technique and timing also appeared to influence outcomes. Balmforth (2009) highlighted the importance of acknowledgement and awareness of differing cultural and social backgrounds and related assumptions by therapists and services. In this study of six participants accounted for their experience as working-class patients in a therapeutic relationship with middle-class therapists. The study emphasised the clinical significance of therapists' capacity to explore their own biases and how these might influence treatment of patients from varying socioeconomic backgrounds. Identifying potential conflicts indicated a negative therapy experience, but only if non-verbal, emotional communications were not taken up by the therapist in the transference.

Carlson (1979) looked at conducting psychotherapy in the first language of three women and concluded that the therapy process was

met with less resistance from participants. The findings discuss the cognitive and affective differences from therapy in an acquired language. Although there may not always be the possibility for therapy in the mother-tongue, this study emphasised the barriers that may be imposed in the experience for clients who must think and talk in a secondary language. The study by Mayers and colleagues (2007) investigated where religious differences were directly addressed in therapy, and used to focus the treatment around the patient's beliefs. Parallels might be drawn here to the impact of a language barrier that lead mothers in Carlson's study (1979) to misunderstandings that were found to be difficult to address. Mayers and colleagues (2007) studied adult therapies in religious communities. These findings showed apprehension from clients engaging with secular based therapies due to a fear of a challenging and or a weakening of faith. However, contrary to expectations, faith had been strengthened in different ways. The researchers concluded that the success was dependent on therapists adapting techniques to engage different communities and individuals. This might then address confused expectations and understanding of the treatment.

Expectations and therapy experience

Expectations of therapy have been shown to influence engagement and attrition over the course of treatment, as Midgley and colleagues (2016) found in their interviews of 76 adolescent participants on a clinical trial. Clients' expectations of therapy and the therapist were found also by Holtforth and colleagues (2011) to be influenced by the

structure of and confidence in the type of treatment. This study argued that frequency, regularity and flexibility factored into the quality of the therapeutic relationship, or alliance. Establishing clients' expectations and addressing these throughout treatment more directly by the therapist was found to be linked to the adolescents' outcomes. The therapist's ability to take a more direct approach was also found to impact dropout rates (Holtforth, et al, 2011). Therefore, establishing the aims of the therapy over the course of the treatment may be important to consider for engagement in any therapy, including PIP. Tambling's literature review (2012) of therapeutic expectancy for couple therapy found that interpersonal expectations between therapist and client influenced the process from initiation, continuance, formation of alliances and outcomes. It was difficult in the study to identify what expectations were, how they were understood by clients and how they impacted outcomes. Discussion of expectations and understanding of referral or reasons for treatment is recommended, but it is unclear whether agreement on expectations would influence therapeutic alliance and therapy outcomes (Tambling, 2012). This review on expectancy suggests that what is important for therapy experience is the role of the therapist in directly approaching and opening up space for sharing, discussing and agreeing to the aims and purpose of treatment.

Glass and colleagues (2001) reviewed 78 studies of the relation between expectation and preference in psychotherapy. This review, like Tambling's (2012), concluded that the differing expectations between therapist and client, influences the outcomes of treatment. Where there

is agreement is in the value both studies find in learning from clients how the therapist might adjust technique to address confusion around treatment aims. It was also important that differences from other therapies be clearly described (Glass, et al, 2001). Furthermore, professional understanding of client needs may contradict with client preferences. This has been shown to negatively influence outcomes and challenge the therapist's capacity to engage the client, and therefore also needs addressing throughout treatment (Tambling, 2012).

Westra and colleagues (2010) qualitatively explored discrepancies between expectations and actual experience for adults in therapy. They found that participants relied on confirmation or disconfirmation of expectations – namely that negative expectations needed to be addressed for good outcomes. Although this was a small study, it adds to the argument that therapists should be prepared to address expectations prior to, during therapy and maybe even for post treatment.

Carlberg and colleagues (2009) investigated children's expectations and experiences of psychotherapy. They found that the value of experience was linked between pre-treatment attitudes and post-treatment ratings. This highlighted the importance of preparing children and their families for therapy and then listening to feedback along the way and adjusting individual treatment. This might align with the importance of measuring and incorporating the views of the child or patient at the centre of a therapy. Similarly, in the literature review by Dew and Bickman (2005) client expectancies are highlighted as a common

factor for improvement and therapeutic alliance, but not necessarily related to attrition in therapy. This study looks at pre-treatment and outcomes to understand how expectations of therapy impact outcomes, but also critically highlights some of the limitations of such studies due to unclear definitions of what is meant by expectancy and whether or how it might fit with outcomes, or not. This too highlights the complexities of making sense of the process of therapy, a qualitatively difficult thing to get a hold of because of the intricacies, in part, in the therapeutic relationship, at the core of such studies, and at the heart of every therapeutic intervention and its outcomes.

Outcomes and therapy experience

Therapy experience has been shown to link to outcomes such as was explored in the study by McElvaney and Timulak (2013), which investigated experiences of psychological therapy for two groups: one with good and the other with poor outcomes. The findings suggested that both had similar experiences but that the emphasis of the therapy differed in that for those where it was poor there was a reluctance to engage fully and there remained a question about why this might have been for these clients. It is possible that the small sample size of the study contributed to the conflicts in the findings. However, the questions about deciphering outcomes highlight the complications of understanding client experience.

Grunebaum (1986) identified negative or harmful experiences of adult psychotherapy where the therapeutic relationship was cold, distant or abusive. These extremes experiences emphasise why it is important

to be aware of, and address, negative experience whilst promoting the intimacy that constitutes a helpful and safe therapeutic relationship and promotes good outcomes. Kuehl and colleagues (1990) contributed to the link between therapy experience and outcomes in family therapy and emphasised that within this population that the capacities of the therapist to be in tune and emotionally available to the clients' needs was linked to the experience for families in therapy. If the client feels part of a collaborative, non-judgemental relationship, the outcomes are more favourable (Kuehl, et al, 1990). Schachter (1990) argued that post-treatment contact, such as interviews that might deduce the patient's experience, might benefit the patient. However, this is argued within the context of an agreed contract at the start of treatment. Having a clear, shared understanding between analyst and patient is vital in the course of a positive therapeutic experience, including post-treatment. Therefore, it can be postulated that the experience of the therapeutic relationship may impact outcomes beyond the therapy itself (Schachter, 1990).

An outcome study conducted by Bury and colleagues (2007) reported on six young people's experiences of psychoanalytic psychotherapy and demonstrate that the pre-therapy variables may impact the overall experience. This study found that for the young people in their study that concerns prior to treatment were learning the process of therapy; the establishment of a therapeutic relationship with a therapist; feeling listened to and accepted. This study provides insight into how to use these accounts to inform the process before engagement by helping young people learn the ropes of therapy, understanding why

they need and are in treatment, roles within the treatment and then the managing of the ever-difficult ending. Like other studies looking at improving engagement by looking at therapy experience accounts there is a considerable need for patients to begin to make sense of what this therapy is, what it is for and how to make use of it. The wider understanding and support for more experiential research within different modalities seems relevant and may be applied to needing further understanding within the profession.

Therapy experience in the context of a trial

The challenges of conducting this type of research within the context of a trial arose in a few existing studies. Midgley and colleagues (2016) described adolescents' experience of participation on a trial and found that the experience was usually acceptable to participants, but that they did not always differentiate or appreciate joint and individual purpose of treatment versus the research assessments. It might be suggested that trial participants require particular clarity from the beginning on the aims of the study and how these relate and/or are separate from the therapy itself. Similarly, Wootten and colleagues (2011) interviewed 14 cancer patients about their participation in a clinical trial. Although overall it was reported as a positive experience, there was a confusion of hope, uncertainty and apprehension throughout. It was not until the end of the trial that the researchers decided that there may be a need to offer a follow-up. However, this would pose complications around whether such a meeting would be part of the trial and/or treatment. MacNeill and colleagues (2016) interviewed 20 adult participants from a health study

post-recruitment and randomisation for a study on behaviours of smokers. Although a medical-based cohort the findings suggested that the participant's input into a clinical trial was felt useful, a motivator for some, but not all. Experience may have been related to the nature of the trial, but this study highlighted the limitation in differentiating between outcomes based on an intervention versus the participation in a trial itself.

Barnett and colleagues (2016) looked at participant experience for 585 pregnant mothers from a previous study on the determinants of children's health and found that participation satisfaction on the study was associated with attendance at clinics and a sense of improvements to health for both mother and child. It was difficult to differentiate whether the benefits were from therapy, or participation. Ultimately, this contributes to the evidence for limitations in conducting therapy experience research in the context of a trial. However, further investigation may be needed into the impact on therapeutic effectiveness and experience.

Summary of findings and limitations

This literature review explored therapy experience, with a focus on parents and their children. "Therapy experience" has been identified in this study as first-hand accounts of participants before, during and after therapeutic treatment. There is very little research into experience of relational based therapies for parents and their young children. There is a particular gap in the knowledge of mothers' experiences of therapy such as PIP. This review explored existing

literature of therapy experiences mostly from adult and individual based treatments. Reviewing current studies initially revealed the difficulty in finding studies specifically on the intricacies of the therapy experience. There were more studies about expectations, outcomes and the qualities of a good therapy, rather than identifying specific traits of experience with the process of psychotherapy. The papers reviewed related to a range of treatments, mostly for adult and individual therapies. The findings highlighted the importance of obtaining feedback amidst the challenges of doing so. The themes that emerged identified areas of importance including: relevance of therapy experience and patient feedback; the therapeutic relationship and key therapist traits; professional constancy and informing the setting; expectations and outcomes of therapy experience; culture and diversity; therapy in the context of a clinical trial. Due to this being an underdeveloped area of literature, this review highlighted that a limitation is the varying description of what constitutes therapy experience; what traits contribute toward a successful treatment; and how interventions might be improved as a result. However, studies show the impact on outcomes so further study is needed to account for the therapy experience of parents and their young children.

Conclusions

This review explored existing studies on therapy experience and highlighted relevance of such studies in understanding what impacts therapy outcomes. Themes emerged within and across the various studies that identified therapy experience as a contributing factor to successful treatment. Therapy experience has also been shown to

inform: professional constancy; the therapeutic relationship and therapist traits; the setting; expectations; technique; and treatment in various contexts. The difficulty in qualifying therapy experience may also be based in the nuanced complexities of variation in available therapies. The review highlighted the ongoing debate around this area of research, and its limitations of such qualitative data. However, this form of evidence-based research contributes to a body of evidence that also informs clinical practice. So, the void in in therapy experience for relational-based therapies in the perinatal period needs further development. An understanding of what aspects of the therapeutic process and relationship influence infant outcomes and the parent-infant relationship in the first year could potentially benefit both the profession and the families it serves.

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Part 2: Empirical Research Project

Title: Therapy Experience of Parent-Infant Psychotherapy for Mothers and their Infants

Candidate number: HJCW9

Word Count: 7985

Abstract

Rationale: This is a qualitative study of therapy experience for mothers and infants in parent-infant psychotherapy (PIP). In a recent RCT there were positive outcomes for mothers, but little or no change for the infants. **Method**: The participants of this current study were 29 of the mothers randomly allocated to PIP during the previous study. Semi-structured interviews about treatment experience, carried out six months into treatment, were thematically analysed. **Results**: The resulting themes from the mothers' accounts were trust, feeling overwhelmed, letting it all out, conflict and confusion, time and working through. **Conclusion**: This study concludes that these themes offer insight into complexities of therapy experience for these mothers. Over time, mothers were able to make use of the trusted therapist to let out all their emotions and feelings in order to work through the overwhelming experience of motherhood.

Literature, background and rationale

Attachment theory. Attachment patterns have been shown to develop within the first year after birth and potentially predict child outcomes. Bowlby's (1969) theory of attachment emphasised the "proximity to the carer" within the context of a human evolutionary strategy promoting infant survival, and the basis from which attachment is understood. It was Ainsworth's Strange Situation (1978) that formalised Bowlby's theories by evidencing infant behaviour within the context of the mother-infant relationship. A "secure attachment" stimulates steady growth of the infant within the experience of reliable attachment figures (Ainsworth, 1978). The capacity of the primary attachment figure to be in tune with and be emotionally available to the infant has been documented as promoting attachment security (Bigelow, et al 2010; Winnicott, 1958, pg. 300; Fonagy & Target, 2005; Slade, et al, 2005; Fonagy & Bateman, 2013; Fonagy & Target, 2005). There are several risk factors that may impinge upon the development of secure attachment patterns, including maternal depression and socioeconomic hardship. However, relational-based psychotherapy like PIP may benefit these parents and their young children (Baradon, et al, 2005).

Maternal depression. Maternal Depression has been shown to impact 10-15% of mothers (Savage-McGlynn, E et al, 2015) and studies have highlighted the impact on child attachment outcomes within the first year (Barker et al, 2012; Brennan, et al, 2000; Cox, Murray & Chapman, 1993; Field, 2010; Goodman, et al, 2011; Oates, 2003; Gress-Smith, et

al, 2012; Liberto, 2012; Teti, et al, 1995; Murray & Cooper, 1997). Cohn and colleagues (1986) suggest that these children can be at greater risk in their emotional and cognitive development. Depression can compromise maternal sensitivity, the mother's capacity to be attuned to her infant and the quality of the parent-infant interaction (Lyons-Ruth, 2008; Schore, 2001; Sroufe, 2005; Murray & Cooper, 1997; Barker et al, 2012; Brennan, et al, 2000; Kim-Cohen et al, 2005; Murray, et al, 1996; Savage-McGlynn et al. 2015). Further links have been made between maternal depression and infant insecure attachment (Weinfield, et al, 2000). Attachment security is also dependent on stress factors including socioeconomic disadvantage, domestic violence, parental risk taking and other family risks, and there can be a cumulative effect on the disadvantage to mother and child (Barker, et al, 2012; Brennan, et al, 2000; Murray & Cooper, 1997). This impacts the mother's caregiving capacities and has the potential to infringe upon child development.

Socioeconomic disadvantage. It has been documented that adverse socioeconomic factors have been linked to difficulties in maternal mental health, attachment relationships, parenting and outcomes for infants (Cohn, et al, 1986; Murray, 1992; Stein, et al, 2008; Teti, et al, 1995). Socioeconomic standing can be associated with some difficulties with child well-being and is often comorbid with other risk factors (Thomas, 1994). The complexities of these disadvantages can predict attachment insecurity or disorganisation (Ackerman, et al, 1999; Cyr, et al 2010). Disorganisation is indicated by exposure to at least five risk factors, but maltreatment alone can be linked to disorganisation (Cyr,

et al, 2010). However, socioeconomic standing alone cannot account for infant outcomes (Ackerman, et al, 1999; Ban, et al, 2012; Barker, et al, 2102; Collins, et al, 2011; Field, et al, 1978; Huston, 1999; Stein, et al, 2008). The level of parental education, family structure, relationships, and the presence of past/current trauma or abuse might be more likely indicators for the development of pathology (Ackerman, et al, 1999; Ban, et al, 2012; Barker, et al, 2102; Collins, et al, 2011; Field, et al, 1978; Huston, 1999; Stein, et al, 2008).

Psychoanalytic Parent-Infant psychotherapy (PIP). PIP is an intervention that works with both parent(s) and infant to address the parent-infant relationship, attachment and development (Baradon, et al, 2005; Baradon, 2016; Kennedy & Midgley, 2007). A meta-analysis by Barlow and colleagues (2015) found that relation-based therapies such as PIP may improve outcomes for mothers and infants. However, that study argued there was not enough evidence to argue PIP as more effective than other similar interventions in the perinatal period.

A recent randomised control trial (RCT) of PIP aimed to determine whether the model could improve infant outcomes and mothers' mental health (Fonagy, Sleed and Baradon, 2016). The findings of that study revealed little or no difference between the PIP and control groups over time on measures of child development, parent-child interactions, infant attachment patterns and maternal reflective functioning. Positive change was determined for the PIP treated mother-infant dyads relative to control on overall maternal mental health; mothers' emotional well-being; maternal representations; and parenting stress.

The data set of the RCT revealed a cohort of mothers indicating securely attached babies, despite the highest levels of depression, at the end of treatment. The unanalysed TEI of mothers in PIP with their infants was considered to account for their experiences, and might clarify the disparity in outcomes. This formed the basis from which this current study evolved. Whilst studies previously looked at experience of therapy for adults and individuals, very few studies have examined parents' experience of relational therapy in the perinatal period.

Therapy Experience. The concept of "therapy experience" has gained attention in recent years due to increasing emphasis on understanding service users' experience of treatment to improve effectiveness and efficacy. A meta-analysis by Levitt and colleagues (2016) provides an extensive addition to the literature that reviews the therapeutic experiences of clients in relation to treatment effectiveness. The authors suggest the client should be at the centre of the therapy and therefore holds important information on what it is like to be in therapy and what is helpful, or unhelpful, in the process. Mental health services are under ever increasing pressure to deliver effective treatment and organisations like CORC (Wolpert et al, 2016) report that service users' experience relate to outcomes in therapeutic treatment. The "therapeutic alliance" (Freud, A.,1962) or the establishment of the relationship between client and therapist; the capacity of the therapist to adjust and make use of different techniques to evoke the client's interest in seeking change; the level and sense of empathy the client feels coming from the therapist; clients' expectations of therapy and therapist; and openly

addressing and thinking about cultural differences and experiences (Levitt et al, 2016; Strupp et al, 1964; Elliot et al, 1989; Poulsen et al, 2010; Strupp, 1964). Identifying areas of change contributes to a better understanding of what patients find most significant and inform future professional practice. Meta-analyses by Levitt and colleagues (2016) indicated patients' experience of adult psychotherapy emphasised the importance of clients' experience directing professional practice, which promotes the patient-therapist relationship. The existing literature focuses on adult or individual psychotherapies, however Salomonsson and Barimani (2017) thematically analysed interviews of ten mothers in mother-infant therapy. This study's themes were the transition to motherhood and relationships with infant and family. The treatment was shown to go some way to addressing relationships, infant and mother needs. However, mothers did not feel enough focus was paid to their needs. Although insightful this study is limiting in informing PIP in that it is a treatment model that emphasises the infant in treatment. A gap remains for therapy experience for mothers in relational-based, parent-infant psychotherapy.

Rationale for current study. The current study aims to provide qualitative evidence of mothers' experiences of PIP in order to inform current practice, and contribute to existing literature. The outcomes of PIP have been mixed and more exploration of experiences may shed light on the findings.

Research question

What is the experience of PIP for mothers with mental health difficulties and their infants?

Purpose

The purpose of this study is to identify what mothers find useful, or not, in PIP. The question is intentionally broad so as to allow enough latitude for the mothers' voices to inform the findings rather than impose pre-existing ideas of therapy experience. This study may also support Levitt and colleagues' (2016) argument of the importance of gaining users' insight into their own treatment in order for more effective future practice.

Method

Design. This is a qualitative study utilising thematic analysis of therapeutic experience interviews for mothers and infants randomised into the PIP group of the recent RCT (see Fonagy et al., 2016 for full details of the methodology of the main trial). Analysis of the interviews was carried out six months post-randomisation. There were differing treatment lengths for each participant. The specifics of this data, including drop-outs, though of interest, was beyond the limits of this study.

The "Therapy Experience Interview" (Fig. 1) is a semi-structured interview of therapy experience developed by the RCT research team. The data from the Therapy Experience Interview (TEI) was chosen for the current study because of questions asked about mothers' experiences of PIP. All interviews were carried out by researchers from

the RCT. Interviews took place in the mothers' homes or local clinic. Transcription was conducted by research assistants from the previous study. The analysis of these was conducted for the purpose of the current study.

Participants. The sample of participants for the current study were twenty-nine mother-infant dyads from the RCT where the mothers had mental health difficulties and were also faced with high levels of social adversity. The sample in this study included participants clinically referred and randomly allocated to PIP. Each met the inclusion/exclusion criteria for the previous study. All PIP cases were eligible for the current study if they had interview data at six-months into treatment. Twenty-nine mothers met the interview criteria and were available for analysis. Although there is a discrepancy in the sample number for this study and the participants in the RCT, this number of interviews was large enough to provide sufficient data for the exploration of therapy experience.

Figure 1.

Therapy Experience Interview Semi-Structured Schedule (ref: Fonagy, et al, 2016)

Therapy Experience Interview (Question4)
The next few questions are about how you found the support you received/are still receiving. 4a. Are you still seeing the therapist? Yes ___ No___ If no, how long did you see her for? 4b) On the whole, did you find the experience of the therapy to be positive or negative? ☐ Very Positive ☐ Positive ☐ Neither Positive nor Negative ☐ Negative ☐ Very Negative c) What parts of the experience were most positive for you and your baby? (illustrate with examples) d) What parts of the experience were most negative for you and your baby? e) What changes do you think could be made to improve the treatment you received? f) What was your experience of (name of site) where you were receiving the therapy?

Analysis. Thematic analysis, as outlined by Braun and Clarke (2006), was chosen for analysing the data set as it allows mothers' voices to emerge. A thematic analysis offered flexibility in approaching the data. The analysis went beyond looking for patterns in the interviews allowing

for the development of themes without the influence of existing theory. In the first stage of analysis, an initial review of the data was undertaken in which all the interviews were coded for initial themes. All interview transcripts were read to become familiarised with the dynamic data. The second stage formalised the coding of each interview in order to align codes with answers given by the participants on the experience of PIP. Codes were systematically developed and collated across the data set. Outlying and contradicting codes were identified for further consideration in the understanding of the mothers' experience of PIP. All data was coded and listed in order to consolidate potential themes. The overarching themes were then reviewed and refined to ensure each worked in relation to interview extracts, and the whole data set. A thematic map identified emerging relationships, and related, repeated themes or ideas. The map identified main themes and sub-themes. Ongoing analysis of the data refined and defined the labels and definitions so that they remain appropriately linked to the mothers' accounts, and clear for reporting.

Results

Six main themes emerged from the thematic analysis (Fig. 2): working through; letting it out; trust; time; conflict and confusion; feeling overwhelmed. The themes reported below were generated during the thematic analysis. Extracts provide evidence for the description of each theme.

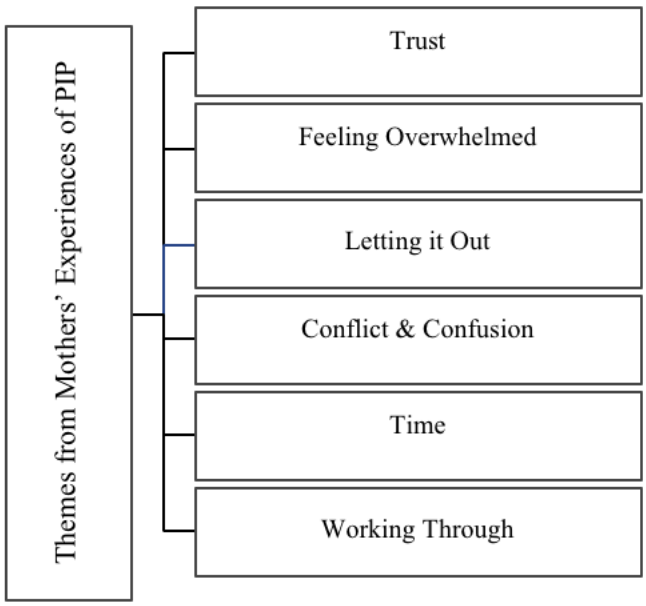

Figure 2. Main Themes on Mothers' Experiences of Parent-Infant Psychotherapy

Trust. The development of trust between the therapist and mother was found to be at the core of the treatment across all interviews. This relied on the development of a safe therapeutic space and environment. Although there was no hierarchical structure to themes, trust appeared central to the other themes. The experience of trust constituted a safe space for mothers to talk and think with the therapist, to let it all out and reduce some of the overwhelming feelings of being a new mother. Trust alluded to therapists' development, maintenance and attention to therapeutic alliance. The alliance in mothers' accounts was important from the start of therapy. This was expressed through projections, or non-verbal, emotional communications, picked up by non-judgemental therapists within the transference.

"… I'm going to be analysed and I'll be the bad mother…" (801)

The feeling that they would be labelled as “bad mothers” reflected their sensitivities to PIP. Attributes of therapists that addressed initial mistrust included a sense of warmth and empathy, pragmatism and openness, and engagement as an attentive, non-judgemental listener.

“…in the beginning it was very hard because ...I can’t trust a person ...I need to time to pass…now I get on well [with the therapist]…” (622)

The mothers needed to know that the therapist cared. The theme of the relationship with the therapist repeated in all the interviews. Over time, the majority of mothers were more able to trust and rely on their therapists. Some mothers felt that this could be felt and seen through improvements to interactions with their babies, i.e. reduction of stress or crying in the room, as a result of the listening, caring and interested therapist.

These changes in the baby were talked about in reference to the therapist acting as a model for the mother in the interactions with her baby. The therapists playing and talking to, and for, the babies was observed by mothers as helpful.

“…[the therapist] has been like my little beacon I know I’ve got her every two weeks …I know that there’s somebody there that just listens...if I’ve got any questions or queries you know about regarding the baby…" (435)

This was not always the case, though. Some mothers struggled to make use of this reflecting on the baby, and remained uncertain about how to play and interact with their babies. It was difficult to ascertain what would have made this easier. However, the difficulty in approaching painful

topics may offer some insight. Reliability of the therapist was felt to be important, particularly if something could not be addressed one week, it might in the next because the therapist would still be there.

"...having a therapy session every week is an opportunity...but sometimes when I'm there ...I don't want to launch into something like that…" (416)

Attendance and punctuality from the reliable therapist seemed to frame the foundation from which mothers could begin to explore difficult issues. By remaining consistently available PIP therapists built up trust and begin to foster the mothers' sense of their own capacities.

"… our confidence has grown together….it's given me more confidence … to go ahead and… try [things] and trust my voice a bit more." (437)

The fostering of a safe place to talk and think attributed a sense that the therapist was an active and caring listener. The safe environment seemed to really be within the therapeutic relationship, and the "cosy and comfortable" room seemed to be physical evidence of this.

"...a safe environment where you ... talk about different things...and knowing that baby as catered for...not worrying that [the baby] was sat in his chair for an hour...positive things..." (430)

Therapy at home was requested in some accounts, but maybe this was alluding to the importance of feeling at home and the therapist being aware of and understanding of the reality for these mothers and their babies. The debate about the location of the therapy might also be considered within the demands on these vulnerable mothers.

In the context of trust three of the mothers struggled to identify who the therapy was for, and who was welcome to attend. A few identify that they would have liked clarification at the start of treatment. Others alluded to the complexities within the parental relationship as being something thought about in the therapy. Referring to the inclusion of fathers by some raised questions in this study of whether partners should be interviewed.

"…it's made a real difference to us and to [include the father] …[the therapist] was really clear from the start that [the father] was welcome to attend any sessions that he wanted to ..." (429)

Knowing who PIP was for and how this might be talked about with the mothers fostered a trusted therapeutic relationship for some. The importance of the therapist setting out the frame of the therapy - the room and the safe, reliable therapeutic relationship - might have addressed initial anxieties. Most mothers identified the presence of a trusted therapist allowed for shifts in feelings and emotions, infant development, and inter-relating between mother and baby.

"…explaining that it's not me and that it's not my fault because I was blaming myself that for you know his behaviour … She was right (laughs). I couldn't believe … at the beginning but now I realize she was right..." (637)

Feeling Overwhelmed. Feeling overwhelmed by motherhood was prevalent in the interviews. There was the trauma of pre and post birth, the existence and responsibility for a demanding baby; impact of mental health difficulties, and potential lack of support at home. Although

appreciated as supportive for most, PIP was also felt by some mothers as overwhelming and intrusive. PIP added to the demands on their time and opened up emotions and feelings. Although therapy attended to feeling overwhelmed, PIP contributed to the sense that these mothers could not manage.

"…I do not wanna burst into tears on the bus… I'd rather be at home and let it ride over me…" (916)

PIP could provide reprieve for some. Within the safe environment and the therapist attentively listening, mothers felt the therapy as a form of escape. Maybe it was this quiet, purposeful space that cultivated the feeling that they could focus on the baby and their relationship. This then allowed some mothers to feel better about leaving the house.

"… I stopped going to work, I stopped seeing people… going to [the therapist] once a week… I was leaving the flat, going there it was a… different world and it helped me a lot…" (637)

It may have felt to some mothers therapy was not for the baby, as this mother refers it helping "me". This was the case in most interviews and there was an emphasis on feeling that PIP was about addressing the mothers' needs, to better tend the baby.

"*...I'm just one person. Can that ever really be enough for him...I think if perhaps if I'd have a stronger family I wouldn't be here now…that makes me very sad…am I going to be enough for him…" (437)*

Mothers often didn't account for the feelings of the infant within the therapy. Many identified being overwhelmed by the baby's needs and

shared that they did not have enough help at home. The therapist then was often perceived as providing support that might otherwise be provided by partners, family and friends. Considering the mental health difficulties and socio-economic deprivation within this cohort, therapy might have been a much-needed space to focus on the dyadic relationship. The therapist's role in this was felt by mothers as helping to focus on the baby and understand more of infant and attachment development. The present therapist almost seemed to give mothers permission to think and talk about anxieties about being a mother.

"...it makes you pay more attention to the way you act … with your child…it makes you feel more conscious about …concerns..." (427)

Noticing and reflecting on the baby in therapy sessions was sometimes painful. For some there was the realisation of the impact maternal mental health difficulties might have had on the baby. One referred to guilt around needing to bring her baby to therapy, when she felt she was the problem. However, for others it was competition with the infant for the therapist's attention.

"…it's all about how [the baby]… how [the baby] reacts to my moods …I'm already feeling …anxious and depressed and then you know, [the therapist] keep saying how [does] that affect [the baby] and does she get lonely…" (619)

Most recognised therapy as building up the feeling that they were enough for their babies. Therapy was experienced as building confidence and

maybe lessening the sense of being overwhelmed. Over time they might eventually began to feel some hope, maybe a sense of change in outlook.

"… It's just nice to know that you've got that light at the end of the tunnel no matter how bad things get…" (435)

Conflict and Confusion. Conflict and confusion was about understanding and misunderstanding in PIP. There was so often a question about what PIP is, who it is for, the aim and purpose. There was struggle for some in understanding why mothers were referred. A few mothers seemed to have developed a capacity to reflect on the need for therapeutic intervention. However, confusion about its purpose may have led to some feeling conflicted about the experience.

"…I don't really know what it was for … I don't think it was improving our relationship … I really felt I didn't need that help or I don't know studying of me… just couldn't do it…" (801)

Possibly this sense of confusion led to a resistance in engagement, but may have been compounded by the fact that these mothers were referred for the previous study to compare treatments. Participation in that study was referred to explicitly by two of the mothers. Confusion over whether therapy was for the purpose of research, or helping the mothers, may have led to passive participation in some cases.

"…whatever you girls are trained to do, you [are] doing the right thing, so I can't suggest anything. I was just happy to help and be there…" (607)

This mother seemed to perceive the experience as helping the researchers as opposed to being helped by the therapy.

It was an added complication for most mothers that PIP was also sometimes an additional service they felt obligated to attend. Possibly this added to a feeling that professionals were observing, and judging, the mother and therefore preventing engagement with the therapeutic process. Furthermore, even though consent was obtained, they knew that their experience might be shared or used as data, as it has been in this current study.

"...sometimes…I'm not ...not quite honest…it's just a service … not super honest…then I regret that ... I leave …think of it later... I regret that it wasn't that honest…" (613)

The feeling of being observed, or analysed, by the therapist as discussed above seemed to be a barrier for many mothers' experience of PIP. For some, the complexities of this conflict persisted and therefore engagement with treatment was compromised. Apprehension about attending, for this and other reasons, might be considered crucial in terms of potential drop-out rates.

"If there are too many things that you are not doing well, then you feel ...this is not true, like you have been misinterpreted… you don't feel like going…" (417)

Mothers admitted to sometimes feeling unable to be honest and let their therapist know when they disagreed. It was the consistency of a safe and secure environment with a caring and non-judgemental therapist that allowed mothers to begin working through these and other conflicts in therapy.

"...[it is] good to talk about things…[it is] the same person as well…Sometimes of course, I [feel] she's wrong…" (417)

The conflicting needs of the mother and baby arose in most of the interviews, but then this desire for focus on the mother could be complicated by other factors. There was often a sense that the baby was fine, and it was the mother who felt she needed the help and support. Maybe it was difficult to feel that during sessions individual needs could be met within the complexities of a dyadic relationship. Numerous accounts suggested that mothers felt conflicted about whose needs were being tended to in the therapy.

"…well for me…yes mummy's doing it. Not for [the baby] …everything's been positive for her… I've had such a terrible time…" (605)

This complicated dynamic amongst therapist, mother and baby maybe also contributed to the feeling of judgement projected onto the therapist. As the therapist interacted with the baby differently, mothers could end up feeling envious of the baby's developing relationship with the therapist. The ability of the therapist to engage the baby seemed to evoke the sense that mothers couldn't do the same. This could have been their own insecurities, but the therapist's capacity to sense this, address it and work through the feelings in the transference was crucial for most of these mothers.

PIP therapists also needed to address cultural complications that arose. For some, assumptions about cultural backgrounds created a

dilemma. Mothers seemed to be calling for therapists who could consider the mother and baby within the context of differing cultural backgrounds.

"… I also don't think everybody completely culturally understands where I'm coming from… I don't think [the therapist] really understands the culture of what it is to be Muslim…" (917)

Cultural confusion also might allude to social and economic conflicts between therapist and dyad. These conflicts with the therapist seemed linked with the confusion around the role of the therapist. Previous experience of professionals seemed to confuse the responsibility of PIP therapists. Expectations and preconceptions of therapy seemed to then compromise the mothers' capacity to feel progress was being made.

"...I know it's not her job and she not going to do it, but I wish she … gave me some help, she gave me some directions or some ideas, but she doesn't… she just listens, writes and steers us around subjects …" (613)

The therapists who addressed these things directly seemed to help mothers reflect on the reasons why they were attending therapy. Of course, it didn't prevent wishing their caring therapists might help with external demands.

"…[the therapist] can be an advocate...someone who can help...I'm expressing my concerns...I'm saying it, but no one there to solve it..." (413)

It appeared throughout the interviews that as the trusted PIP therapist began to create a comfortable and safe environment mothers sensed they had a caring professional, different from what they had

previously experienced. This development for some allowed them to feel that they could begin to offload anxieties. Increasing reliance on PIP did not however change life outside therapy. PIP was therefore used as a space to offload and escape that reality.

Letting it All Out. Letting it all out was about mothers using the therapeutic environment for purging the mind and creating space for feelings and difficult thoughts. This theme is about the role of PIP in giving mothers space to let it all out or as one mother nicely put it "have a spring clear out".

"…it's a bit like having a spring clear out…I don't really wanna do it…[then] I'm talking about things that I'm not dealing with…"(916)

The capacity to purge the mind seemed possible within the achievement of a therapeutic alliance. Devotion to the purging of and thinking about feelings required a comfy and cosy space.

"*If I weren't going to those sessions … I would maybe not dedicate…or devote time to speak about the feelings …" (427)*

One of the challenges of breaking down defences and opening up was mothers often felt vulnerable afterwards. They would let it all out and then need to leave – as any patient might – and return to the reality of their lives with their baby. Many wished for additional time at the end, maybe to hold onto the safety of their therapeutic space with the therapist.

"…I've come back home feeling really depressed, really just kind of overwhelmed with everything that I let out...[but then]…I need someone to kind of let it all out to …" (639)

PIP offered the chance to escape the reality of their lives and feel safe enough to focus on the developing relationship. Therapy reportedly offered each mother some time to talk with someone neutral and separate from family and friends. Otherwise, most of the mothers alluded to not feeling able to talk openly with others about the dark thoughts they had, particularly about the baby. In turn, the therapist became the trusted, safe object with whom they could confide.

"…It's quite nice that we come together and then we have a chance to meet somebody who is outside friends or family…" (911)

The presence of the baby highlighted the emphasis on the relationship between mother and baby and offered opportunities for bonding. Sessions were often devoted time for talking and thinking about feelings and this came to be valued time.

"...talking about things with baby there [made it] easier to think about this being a situation that's related to me being a parent…" (429)

Letting it out was often helpful, but not easy for most mothers. Possibly trust in the therapist or the rhythm of the sessions cultivated the capacity to work through more difficult feelings like the impact of their own mental health on the baby. Therefore, the therapy could become a space in which the mother might eventually come to feel comfortable to let it all out.

"…to be able to sit there and talk to [the therapist]… is a rare thing … she's been absolutely fantastic…" (435)

Time. Time was about time in and between sessions, time in treatment and time for change. There was little consensus on session length or frequency, but the concept of time played a role in all the mothers' accounts of PIP.

"…[I would like] to have a longer session because what you have for me is really short, but a long session I'd appreciate that…" (434)

Therapy was often felt to be time consuming and some indicated this to be linked to why they didn't attend sessions. This was already a cohort of overwhelmed mothers. Proximity to therapy sessions was factored into whether PIP was time consuming and whether mothers managed to attend. Session time was often in conflict with other demands and added to pressure on mothers. However, the regularity of therapy played a role in establishing routine when there was often loss of one after the birth. Others reported therapy disrupted routine as the time interfered with feeding or napping times.

"…getting organised…keeping to a routine I found a bit difficult so that was a the negative …" (430)

Punctuality was often a challenge for many mothers and contributed to the sense of inflexibility from therapists. If mothers arrived late they reportedly didn't have the full fifty minutes they expected. Although punctuality and reliability were traits that mothers attributed to the trusted therapist, but they struggled to mirror this.

"…I come too late and then we don't have enough time …it was difficult to come on time…" (911)

Once in the sessions there were differing reports of what they expected from the structure of the sessions. Some hoped that with a more directed therapy full of strategies and practical advice, things might improve more quickly. Less structured sessions of PIP were also the space from which feelings and emotions could be explored without agenda from the therapist. Then, of course as above, this left them vulnerable between sessions.

"…the ways ... therapy is conducted could be different ...this plan that I am talking about would be put into considerations … I could find answers in a shorter period of time ... it would take a lot of time to ... to find what I am looking for…put things inside and have to be okay..." (427)

Mothers therefore reported that considering session frequency is important. The time between sessions was highlighted as a difficulty. Contact with the therapist between sessions was linked to a sense of availability from the therapist.

"…the visits every week, it's quite nice, it's not that I'm left for two weeks feeling vulnerable after exposing my issues…" (911)

Time away, or breaks from therapy, highlighted the absence of the therapist and one mother talked specifically about the time between sessions in a way that showed the impact of attending regularly.

"…And then when we had the break in August just before we broke I was feeling really happy and I thought I don't really need to do this anymore but then August was awful … when we came back I realized … [the therapist] does …help…" (625)

Working through. This theme described the experience of needing space to process the difficulties of motherhood such as perinatal mental health; past experiences and trauma; development of the baby. Observing changes in the baby were linked to therapy. Change in the mothers was also linked to the therapy they had had or were still receiving. There seemed to be something in working through where they felt stuck, that for some mothers allowed space for noticing and reflecting on change.

"...when [baby] is talking to the lady he would lash or want throw something... but now he actually plays …an... improvement …" (609)

Many reported moments in therapy made it difficult to return. It was crucial therefore that the therapist was experienced as the non-judgemental listener. Even though things could be painful this was the place dedicated to talking and thinking about things there was no time for elsewhere.

"…it can be upsetting... you sometimes find things ...you don't really like... it's not nice to discover those parts or to speak about things that aren't nice. Um…it can be sad and painful..." (427)

Revisiting the past and childhood experiences was often painful and difficult, but seen as useful. Most did not want to revisit childhood experiences, but often felt it to be helpful and even important within the safety of the therapy. Most mothers referred to the interview (AAI) that explores their own childhood. Most found it very painful to work through and some found it helpful in addressing the relationship with their infant.

"…there was quite an intensive interview about my childhood [AAI]… I didn't know it would actually shake me up that much … I never talk about my childhood … it explained a lot about my relationships … how my daughter is behaving now… I try to compare it to how I used to behave, and I see where it's healthy and where it's not … [my childhood] had its bads and goods… at the time it wasn't a good check-up, I didn't like it … but maybe it was something that I needed to think about…."(639)

Feeling stuck seemed to be at the core of the mothers' experience. Many suggested a sense of feeling trapped by their new responsibilities and therapy offered something different. Therapy was felt to be a safe space think and talk about issues that otherwise would not be addressed. Mothers began to notice their developing babies.

"…it means that you get to get away from that environment you know where we feel we're stuck most of the time. That really makes a difference..." (916)

Discussion

This was a qualitative study of therapy experience for mothers with mental health difficulties in PIP, who participated in an RCT. The purpose of this study was to better understand the experiences of PIP for mothers and their infants. This was of interest due to findings from a recent RCT of PIP that concluded mothers' well-being improved overall, but that parent-infant interactions and child outcomes did not. Thematic analysis of the TEI produced six main themes: trust; feeling overwhelmed; letting it all out; conflict and confusion; time; working through. It was difficult to

analyse therapy experience as mothers often recounted personal anecdotes, rather than the process of therapy or the therapeutic relationship. There were also notable limitations to the TEI in that it did not directly explore relationships, the infant or partners in therapy. This contributed early on to the complexities of exploring the research question and the dynamics within the context of the RCT findings.

Trust within the therapeutic relationship was established and maintained via the evolution of the therapeutic alliance, which has been linked with therapy outcomes (Brenner, 1979; Dickes, 1967; Freud, A, 1962; Greenson, R. R., 1965; Zetzel, 1956). Themes in this study were not intentionally hierarchical, but the trust within the alliance appeared pivotal in the foundation of therapy experience. A safe, secure environment with a trusted therapist nurtured new, overwhelmed mothers in managing their feelings. Framing the therapy, the room and contents, its purpose, the reasons for referral, and the role of the therapist proved essential. Winnicott's (1996) "holding environment" perhaps accounts for some of what these mothers needed, and experienced, from therapists who could model and facilitate the appropriate preoccupation with the infant. There was little suggestion of what particular help mothers would have preferred if they found PIP unhelpful, but one responded with hope for a "magic wand". It may be that PIP is such a complex experience that the TEI questions were not directed enough to elicit response on the relationship with the therapist, or the infant. Themes did emerge to describe this dynamic relational experience.

These interviews demonstrated the formidable role PIP therapists played in restoring the emotional well-being of these depressed mothers. The development of the “trusted therapist” improved over time for some of the mothers, and seemed to alleviate initial apprehension. The development of trust addressed what some mothers described as a “judgemental therapist”. This seemed to be a non-verbal communication that mothers may have projected onto the therapist because they felt attending PIP meant they were “not good enough” (Winnicott, 1969). This was powerful enough for some mothers’ attendance, and therefore participation in the RCT. However, if therapists picked up on and addressed non-verbal cues this could encourage mothers’ reflections on where they and/or their infants were stuck. Some felt enlightened, albeit painfully, by the exploration of their own childhood histories. Although many mothers worried about the impact of their past experiences and mental health on the infant, all mothers identified this reflective space in some way. Most of these mothers also considered the therapist as theirs, highlighting a possible link with the differing outcomes of the RCT between the mothers and infants. One mother honestly reported that she wanted the therapist all to herself. Conflict arose when the therapist’s attention appeared to be on the infant. Yet, the “listening, caring therapist”, for some built, the therapuetic alliance needed to nurture self-esteem and confidence within the mothers. The majority were able to link the role of the “present, listening therapist” to improvements to their wellbeing, and understanding of the infant and development. Some felt more able to meet the needs of the baby. Furthermore, some noticed and

work through painful associations toward the infant, such as the sense of guilt a few described when thinking about the baby needing therapy.

Limited reference to babies' or partners' presence in therapy offered further insight into the possibility of limited understanding provided by RCT outcomes. Mothers' capacity to reflect and talk about the infant or partner may have been dependent on reflective functioning. It would be interesting to conduct further study into the potential link between infant outcomes and mother reflexivity by the end of the RCT (Slade, et al, 2005). However, it is noted that some could freely reflect on the importance of the baby's presence, a considerable achievement in PIP (Baradon, et al, 2005). Although there was also little accounting for fathers or partners, there was some reference to partners in the task of working through complicated parental relationships. In three accounts the therapists' explicit invitation and inclusion of the father was reported as helpful, but otherwise they are rarely mentioned. This could perhaps relate to the mothers' perception that PIP is for them and so like the infant, the partner is not held in mind when asked about the experience. Despite this, it does seem curious that fathers are not interviewed on their experience and/or maybe in a question to the mothers within the TEI.

It does seem limiting to lay responsibility of describing experience on the mothers. The TEI is more open-ended so it accounts for mothers' remembered accounts of the treatement, and any changes to their own emotional well-being, and/or to the relationship with their baby. There were accounts of change in infants over the course and this tended to include something about the relationship with the therapist. What we

know as the transference, non-verbal communications, may have accounted for the challenge mothers'may have had in describing this intimate experience without more direct questioning. Despite the limitations of the TEI each mother described a unique PIP therapist that catered to needs of each dyad, or triad for those where the father was included. Interestingly, mothers who accounted for the relationships in the room, with the therapist baby, were those most enthusiastic about recommending the treatment at the end of the interview. It is difficult within the confines of this study to examine this more fully, but may be a useful and interesting further bit of research to pursue.

Unbearable moments in therapy, understood here as the negative transference (Freud, 1914), were accounted by some mothers as crucial to progress, but some admitted that it made it difficult to return. Mothers sometimes felt left with difficult feelings between sessions, but within the transference relationship this is taken up by the therapist (Baradon, et al, 2005). It would be surprising if the mothers did not find separations and transitions difficult, but the therapist would, as part of the complex task of the treatment, be addressing the difficulties with transitions and change to facilitate change within the attachment behaviours (Baradon, et al, 2005). Maybe for these particularly vulnerable mothers there was some need for attention between sessions, but also perhaps an achievement to miss and come to depend on their therapists.

Including service users in the decisions around their care has been shown to improve outcomes (Abrines-Jaume, et al, 2016; Edbrooke-Childs, et al, 2016). Therefore, including parents in decisions before and

during treatment might then be considered important for future practice. This then contributes to the discussion about the delivery of the rationale and purpose of the treatment. Addressing conflict and confusion about PIP might alleviate anxieties about attending. Furthermore, the collaboration of professionals could be an important component for bringing together the different parts of the mothers' lives.

Limitations. The thematic analysis (Braun & Clarke, 2006) is well known and so are its limitations. The data was transcribed by researchers during the main study and so there was no control over the transcription. The reported method of transcription was done systematically and thoroughly. The thematic analysis was appropriate in providing an understanding of therapy experience for mothers in PIP. The sample included interview transcripts from all PIP mothers who were interviewed at follow-up, regardless of whether they engaged in treatment and irrespective of the outcomes. Further research might involve more specific purposive sampling that focuses on subgroups within the sample such as those who did or did not engage in therapy; those who did or did not have positive outcomes. The limited number of questions on the TEI resulted in rather short interviews in some cases, while others were more detailed. Further questioning or a different structure of interview might have produced different response. Furthermore, fathers or partners were not interviewed and considering some were potentially involved and mothers' accounts explicitly requested clarity around their involvement might need further consideration for future practice and study. Although difficult to measure, the babies' experience is a component of the therapy

and reporting was reliant on the mothers' accounts. Considering this is a parent-infant relational based treatment this might be an important consideration in future use or adaptation of the TEI. These mothers were participants in a large RCT, and this was felt by many to be part of the therapy experience as reported above. Further studies may need look at therapeutic experiences in more naturalistic settings, such as within the perinatal clinics in which this form of therapy is practiced. Some of these limitations might be considerations for future study.

Conclusion

This qualitative study concluded that for the mothers interviewed each had a unique experience. It was evidently important that individual needs of these vulnerable mothers were accounted for, but the diverse accounts revealed overarching themes that explore therapy experience for a cohort of mothers in PIP during an RCT. The development of trust between therapist and the mother-infant dyads was crucial in all accounts –a dynamic process developing from before the start of treatment. Mothers needed to sense that they had a non-judgemental, concerned therapist who could manage and model the complexities of the relational dynamic within the transference. Time in a safe and secure environment cultivated trust that in turn created space within the mothers' minds to think and reflect on their own and the babies' difficulties and babies. The mothers felt able to address overwhelming feelings by letting it all out in therapy sessions and began to work through areas in which they felt stuck. PIP was reportedly overwhelming and intrusive for a few mothers, and although this could be explained theoretically via the concept of

projection considering the vulnerability of these dyads such powerful feelings might have impacted attendance, and perhaps drop-out. The conflict and confusion about PIP, its purpose and the role of the therapist seemed to need framing at the start, but it is possible that these conflicts reflected the internal conflict felt by these mothers not just about attending PIP, but about the enormous task of becoming a mother. PIP was seen to be about working through overwhelming feelings and conflict with a trusted therapist over time. Many mothers felt relief from exploring their own past, but time between sessions was often when mothers felt PIP's absence, and therefore its increasing significance. Mothers identified the babies' behaviour and interactions with the PIP therapist as a marker of change in the treatment, but it would be interesting to further research which mothers were more able to think about and reflect on the baby's presence and changes. There was no specific question about the baby or father in the TEI and so it was difficult qualifying these experiences. Ambivalence about PIP remained throughout for most of the mothers, but the complexities of this were beyond the limits of this study. This study may provide some clinically relevant findings and insight into the outcomes of the previous study, but it has thrown up further questions. Though there are still areas for further research, as a collective these mothers and their infants provided invaluable insight into the therapy experience of PIP during the first year after the birth.

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Part 3: Reflective Commentary

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Introduction

The rigorous experience of this clinical doctoral training has offered opportunity to engage theoretically, empirically and practically with the increasing complexities of children and young people's mental health. It has been a grueling yet rewarding endeavour. Early on there were multiple aims including: the meeting of an ever-increasing demand on health services; to confidently and critically go forward with evidence for psychoanalytic psychotherapies as a treatment choice; to contribute to the current and ongoing body of research into this field. The undertaking of clinical and doctoral work simultaneously has demanded determination and perseverance. This is a reflective commentary on this process of bringing together the pieces of this dynamic identity of research-clinician.

Background: Back to Basics

The clinical audit early on in my training offered experience in taking initiative and working collaboratively with colleagues, whilst contributing to the effectiveness of a Service. In addition to the research components of the teaching, this exercise prepared me well for the more rigorous process of collecting, analyzing and presenting findings for the empirical study. I had not anticipated the role of this audit both in my own profession and the wider Service. The involvement of the psychoanalytic perspective provided opportunity for reflective space in the Service that had not otherwise been available in research. I offered time and a different outlook as I embarked on the rigour of this doctorate.

As I settled into my new training placement, and under the advisement of my Service Supervisor, I explored with the team what might be of interest. I soon found an ally in one of our Clinical Psychologists. He was in the midst of conducting various pieces of service-based research, and suggested I get involved. Fortuitously, I arrived after the initial phase of a CYP IAPT transformation. An initial audit, conducted as part of that process, revealed poor understanding of IAPT and negative attitudes from staff. At the time I had very little understanding of what that meant, but I was curious why this initiative, meant to improve the effectiveness, had failed to engage this Service I had just joined.

The Clinical Psychologist took on a sort of supervisor role. I learned that a questionnaire had been developed for the purpose of measuring staff attitudes. This remained the measure for the re-audit. There were specific questions about why attitudes towards, and reception of, IAPT were so poor. Furthermore, psychotherapists had not previously shown an interest in audits. The preconception was that the psychologists conducted these. It was hoped that I might be well placed to add some reflective focus groups, as well as address stigma behind professional assumptions. Upon reflection I truly appreciate the capacity of my colleague to be candid about some challenging realities faced by clinicians and the Service. Meanwhile, he inspired my understanding of why this sort of research was crucial, and why my involvement would be of value. This collaborative relationship remained throughout the project. This initial grounding in a truly collaborative piece of work with another

modality stimulated similar relationships. As my own theoretical stance developed, learning to debate with different colleagues along the way promoted the establishment of my own identity as a psychoanalytically informed psychotherapist. This project was the beginning of establishing a strong position within the team. This psychology colleague has since continued to further our pursuits including service wide trainings and adaptations of IAPT standards to cater to the needs of the Service. The impressive modelling of how collaborative work of different modalities might nurture a more effective team, and provision of interventions, has served me well.

Learning to make use of supervision

As a new trainee, I initially felt I had to get on with things without question. Despite there being no specific criteria for prior experience in conducting this level of research, I felt I would be expected to know. I had not considered how much I might be able, and need, to rely on supervision. Perhaps, due to the guidance and time from my colleague, as well as seeing out the process with my research supervisors, I managed to offer something of value to both the Service, and me. However, presenting this to the Trust and writing it for the academic purposes of the doctorate were very different prospects. I had to learn the humility needed to cope with the ebb and flow of research. Though I found revisions painstaking, this process taught me some of the toughest and most valuable lessons.

In the initial stage of exploration of inspiration for the empirical study, I investigated a variety of data with supervisors. I was first struck

by a cohort of mothers with the highest levels of clinical depression from the recent RCT on parent-infant psychotherapy (PIP). The mothers had come through the study with securely attached babies according to the Strange Situation. I wondered what it was about them, the support around them, and/or the psychotherapy received. I initially explored the idea of resilience in mothers and babies. Though a fascinating cohort, this was a saturated area of literature and I struggled to identify a gap. I wanted to know something about what had promoted this change in the mothers and their infants. Yet, change seemed complex to identify with so many variables involved. I felt stuck.

Research workshops and supervision were vital in working through what I was interested in, and what data was available. It took time and patience, but initially I liked the idea of contributing toward understanding findings of a recent RCT of PIP. During a winter research workshop, I worked closely with supervisors toward a proposal incorporating my interest in these mothers and their infants, as well as PIP itself. It was a fundamental moment when I saw the benefit of decision making and the role of supervision groups. I needed to step away and look from a different angle. I also had to take direction from others who could, from their experience, urge me forward. The work that I had put in wasn't actually lost, as I had initially thought either. I had a grounding in literature as a basis of understanding of what my project was, and was not. Furthermore, it was evident that therapy experience for parents with young children was an under-researched area. With a clearer direction I was much happier, too. The data from the therapy

experience interview (TEI) was ripe for analysis. Given I had already gained some familiarity of the TEI in group supervision, I felt comfortable and interested in delving into the accounts of therapy experience from the 29 mothers.

As I approached data analysis I needed further teaching on the intricacies of qualitative methods. I had already attended a few workshops, but there was opportunity to have a refresher on IPA and other forms thematic analyses. This was timely as I was looking for a clear method that would create some ease in the analysis of 29 interviews. I was also intent on the mothers' accounts coming through, rather than impose existing theory or understanding. The method seemed somewhere between grounded theory and thematic analysis. A thematic analysis, though, as outlined by Braun and Clarke, seemed most appropriate. It offered a detailed structure, whilst maintaining a flexibility. With close support from my main research supervisor I immersed myself in the data. I also relied heavily on triangulation to ensure coding was grounded in the data, without losing the mothers' voices or the overall picture. There was an added complication of what came to be known as "reading between the lines". In supervision this was identified as a challenge possibly attributed to simultaneously training as a psychoanalytic psychotherapist. There was this tendency to interpret, or elicit meaning from the data. Often this wasn't necessarily grounded in the mothers' accounts, but rather in the meaning I was placing on the data. It seemed instrumental to diverge the two fundamental tasks I was undertaking. I was learning to interpret transference and a patient's

presentation in the therapy room, whilst also learning how to analyse qualitative data. It took practise to get the hang of this and develop a comfortable rhythm that kept my tendency to interpret to one side in my mind. Of course, this was a challenge given these were skills I was acquiring and practising simultaneously. Then as I began to separate out the two sorts of thinking, I became too detailed in the discourse of the mothers' responses. This was in part a reaction to an anxiety around the propensity to over-interpret. It became apparent, too, through sessions of group coding, that the account of therapy experience was difficult to pick up. I really could only draw this out after some attempts to code in different ways. During the process I received affirmation when my codes matched well enough to others' during a couple of session of triangulation. This process was arduous, but the themes emerged as I gained confidence in the rhythm of coding, and familiarity with each participant.

What truly progressed this practice was an outlet for internal thoughts and interpretations. I was advised to create a column on my spreadsheet for these. This space divulged free associative sort of thinking that emerged as I coded, and proved invaluable in the discussion of results in the final paper. I also maintained a steady research journal throughout as a reflective space for noting challenges and triumphs along the way. The difficulties of data analysis seemed to find parallels in the development of clinical technique, too. I was being trained in the art of psychoanalytic interpretations and practicing the level of sensitivity and depth of them in my clinical cases. Parsons (2009) suggested in the

chapter on “An Independent Theory and Clinical Technique” that there is an art to “waiting” as an analyst. The “waiting analyst” is not one that is doing nothing, but rather attuning to the patient. This skill, like that of the thematic analysis, is developed under careful direction and supervision. Learning the optimal distance from each individual patient was not necessarily about functioning with the purpose of providing an interpretation. Furthermore, in the Independent tradition I was learning reliance on theoretical understanding might prohibit imaginative freedom in the therapy room. This appeared so relevant to conducting data analysis, too. The steady, reliable and consistent frame of therapy, or a clear method around the data, allowed for the participants’ and my patients’ experiences to come through. I was gaining a true appreciation for patience as a research clinician. Sharpe (1943) in a chapter on the training of candidates suggested that the pace of the learning process, like that of the patient in analysis, be set by the student. This requires a safe space for student to both acquire technique whilst also proficiently supported by relevant illustrations of work already done. Only then, with this firm foundation, can the new clinician begin to move forward independently. This combined training demonstrated the joint effort needed to sensitively receive and engage with evidence based on experience.

Research and clinical realities

As data analysis moved forward, I learned too of the critical time for the profession. I was, with great consideration from my superiors, moved to a new clinic where I would see out my training. This move had

many consequences. One, was an acute appreciation for my senior colleagues, and training school, who did what they needed to protect me. I was well looked after, but I watched colleague after colleague disappear. I saw children and their families lose the care they needed. Though handled as sensitively as was possible, I terminated patients' treatment with little warning or preparation. I found, with support from my team, alternative provision for these families, but I ultimately lost my training base. The security expected from the consistent and robust frame of psychoanalytic psychotherapy could not be sustained. I was lucky enough to have supervisors and the training school to contain the enormity of my anxiety during this. I was also welcomed by a team that provided the secure base that necessary to uphold the clinical side of my training. Though troubled by the situation, it felt apt that this was a specialist team in post-adoption work that took me in with so little question. Whilst this transition was happening I was revising the audit, working on my first clinical paper on non-intensive work, conducting my first STPP case, preparing for an oral examination on assessments and beginning an initial literature review for my empirical study. I was taking on new clinical cases and terminating previous ones. I felt under immense pressure to get intensive clinical cases going and find my place in this new team. I truly came to understand and appreciate the role of my advisors and supervisors. Each stepped in to support wherever possible. I also took solace in teaching days. Though asking for help did not come naturally, I needed it. There was also, as ever, a need for effective communication across the clinical and doctoral components.

Though I relied heavily on my progress advisor for this, I found that there was space during supervision sessions to communicate the stress I was under. Though each session had its purpose and structure, I was introduced to the importance in considering the impact of contextual factors. Of course, personal analysis played an enormous role in my capacity to manage the extraordinary demands at any point during this training, professional or otherwise. My resilience was tested, and grew exponentially.

I needed to find ways to carve out time for research. Although there was, and should be, a dialogue between the entities of clinical and empirical practice, it seemed that at times they also needed to be kept compartmentalised. I needed time dedicated to research. In discussion and agreement with my Service it was deemed half terms were most appropriate. Families were usually on a break from therapy and so my mind could focus elsewhere. In reality, every spare moment was filled to keep up with the demands, and it felt as though I arrived at supervision meetings with no energy to move forward. Yet, these individual and group sessions always boosted me. I sought solace in this communal feeling of being pulled in too many directions. These gatherings also provided direction, and re-centred my thinking. My research supervisors were all incredibly available and this was particularly noticed in my main supervisor. From my point of view, time was given whenever I sought additional meetings and phone conversations. This additional space helped plan and re-plan. My supervisor seemed to appreciate the sensitivity that was needed and learned just how and when to push me,

and when to hold back. I learned, for instance, that I had to focus on one thing at a time wherever possible. If I had a clinical paper, I would take time for that and return to the research. A balance had to be struck or the waters were muddied. Time was a most precious commodity, but there was collaboration and cooperation from all supervisors and advisors in coordinating the various components. I was learning to communicate effectively with them, too. I no longer tried to cope alone. This fostered a growing capacity to meet deadlines, whilst learning to enjoy and engage with the research. I did not anticipate enjoying it as much as I have. In fact, as I worked with my supervisor through various revisions, I realised how far I had come. Of course, there was and still is plenty of room for further learning.

I began to find the systematic reflexivity of the empirical study helpful. It was so fundamentally different from the clinical writing and academic expectations, but I began to go back and forth with more ease. Ironically when stuck with one I might turn to the other. I was also building a picture of what it might be like for these mothers attending therapy. I wondered often how this might correlate to my own patients or to my own experiences of being in analysis. The experience wasn't just about being in the room with the therapist. It started before they left the house, before they even came for treatment. The parallels felt endless in correlation to the training experience, too. As I presented and discussed challenges along the way I discovered it was not just what mothers said, but what they did not say and why. The why was not always in the data. I did not always find out about therapists' technique, for instance, but then the

questions didn't specifically ask. The open structure of the interview relied upon the mother to talk about traits of the therapy process. I continued to learn how to put my own agenda aside, so I could learn from these mothers' moving accounts. Simplifying my aims also helped to maintain a more open stance. Though mothers wanted some clearer understanding of what PIP was and why they were there, it seemed relevant that in practice it was so difficult sometimes for young people I was treating to identify the aims or purpose of their therapy. Leaving it open sometimes helped them to emerge naturally. I noticed that whilst different processes were going on the accounts identified specific needs and experiences, and the clinical and empirical training experiences informed each other.

Learning to present and revise findings

Preparing for and presenting at the SPR conference taught me much about becoming a research clinician. It felt apt that as a cohort we were part of a conference themed around the concept of improving dialogue between clinical and empirical work. I realised the world-class training I was on, one I admired for the ambition of trying to nurture future clinicians that could, and would, engage with both worlds. It was a chance to practice the presentation of findings, and experience how an audience might receive them. I found that this interaction with the profession stimulated a dynamic discussion about work with parents. This was a lovely way to look ahead to the final year of the training ahead and pull together all the components.

I was also beginning to find that senior colleagues in the Service were providing opportunity for the presentation of papers from trainees. Many were keen to hear about this clinical doctorate and found that our termly psychotherapy meeting was increasingly the place to invoke dialogue with practicing clinicians. We were encouraged as trainees to take a chance to practice presenting. I often found myself apprehensive about sharing. There was this anxiety about whether it was interesting, and whether it was good enough. However, I have always been pleasantly surprised by the helpful input these discussions contributed to my thinking. It also clarified how relevant the research is to those in the field. I have wondered what it means to psychotherapy colleagues to have research presented in, or translated to, a language that they understand. So many of the papers we had critically analysed in the research workshops early on in the training, seemed aimed at specific professions with different terminology. This space once a term for the profession, and in multi-disciplinary team meetings, evolved into the opportunity to discuss and debate evidence. Clinicians were keen, but needed it presented clearly. As I now know, it takes concentrated attention to engage with research.

I also decided to write a new literature review on therapy experience. Though frustrated by what appeared to be lost time, the initial review of attachment and resilience factors grounded why therapy experience research was important. Strupp's (1988) paper on therapeutic change, for instance, identified that the therapeutic relationship might address difficulties a mother was facing with her infant. However, patients

were found to need help in making use of the therapeutic relationship. So many had their own difficult histories and attachment patterns rendering any new relationships problematic. I initially felt that it hadn't made sense to go back to the review. However, I had gone on to do further review the literature on therapy experience for parents and children and I wanted to reflect this in the final presentation of the study.

The literature review was a laborious undertaking. I am not sure I fully appreciated the level of nuance necessary for a successful review. Interestingly, existing literature around attachment relationships and resilience factors for depressed mothers and their infants fueled the direction of the study. Therapy was identified as a protective factor. So, in pursuit of why it might be, I needed to know something of existing literature on therapy experience. This additional piece of writing, though valuable, added time and effort to my already demanding schedule. It was difficult to balance this adjustment with the ongoing submission of other papers. Upon reflection, writing styles are an area where the two arms of the course felt difficult to navigate. I often thought of this as something of a physical shift in my brain, but I was slowly training my mind to function in both. The extensive review of literature informed my clinical work, too. So many of the children and young people on my training caseload were living examples of the long-standing impact of relational and emotional deficiencies in the first year. Though there is theoretical basis by which to make sense of the complexities of my vulnerable patients, the empirical data evidenced why support in the early years of life is so vital. I also gained understanding of what might

influence the experience of therapy for my patients before they even arrive in the therapy room. Somewhere in this process the pieces of my emerging identity began to merge.

Conclusions

"The product of the doctorate is not the thesis, but you", Nick Midgley offered one day. I have also heard someone suggest that doing a doctorate is about learning how to do a doctorate. Slowly but surely, I have realised that this whole process was never about knowing, but about learning how to conduct doctoral level research, applying it to clinical practice, and vice-versa. Modelled proficiently by those supervising and guiding me on this journey, I have finally found my way through, and upon reflection have come to appreciate this collaboration. Perhaps we need not only to conduct research, but feel capable to think critically about it. We might need to question it from time to time from a firm grounding in our unique clinical experience and theoretical knowledge. I certainly had not anticipated this joint task at the start but feel convinced that it is critical that psychotherapists engage. The discussion and debate are vital in the development of sensitive and appropriate care and treatment for children, young people and their families. I look forward to consolidating all the components of this incredible learning experience as I move forward in whatever future endeavours I pursue.

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