A qualitative exploration into health visitors' experiences of working with infant mental health concerns

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A thesis submitted for the degree of Professional Doctorate in Psychoanalytic Child and Adolescent Psychotherapy

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Date of submission for examination January 2020

Abstract

This qualitative study explores health visitors' experiences of working with infant mental health concerns, specifically with children under-five. Increasingly, health visitors have the onerous task to monitor and give advice on the health and development of young children, sometimes in complex family situations. There are several studies regarding the critical importance of the early years, such as, '1001 critical days: The importance of the conception to age two period' (Cross–Party Manifesto, 2013). This research seeks to discover how health visitors think about and act upon infant mental health by asking the question, "What is the lived experience of health visitors working with the mental health of under-fives which is of concern?"

Data was gathered from health visitors using the 'Free Association Narrative Interview' (Hollway and Jefferson, 2000) this psychoanalytic method supported the analysis of less defended material. Following data collection, thematic analysis was applied to systematically analyse data. Three categories were identified relating to health visitors fluctuating states of mind; 'anchored,' linked to feeling secure regarding skills to support families. 'At the edge,' describes when health visitors experience unchartered territories and feel less secure regarding skills and capacity. 'Adrift,' is a worrying state of mind, closely linked to feelings of isolation and disorientation.

Further analysis found categories shared four core elements; sense of agency, linking, capacity and systems structure. These elements provide an internal and external framework needed for health visitor practice. This research found that risk impairs health visitor ability to mentally or practically access these elements.

As a child and adolescent psychotherapist, this study is contextualised within the field of psychoanalysis. Psychoanalytic concepts applied to the findings highlight how health visitors' states of mind fluctuate depending upon their ability to mentalize. Furthermore, if abilities and capacity become impaired health visitors become susceptible to secondary trauma.

Word Count 299

Declarations

I declare that the content of this research is all my own unaided work and that ethical approval has been granted by IRAS and TREC. Confirmations of these approvals are in the appendices.

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Acknowledgements

I wish to express my sincere thanks to my research supervisor, Dr Jenifer Wakelyn, for providing me with encouragement and sharing her expertise. I would also like to extend my gratitude to my clinical supervisors, Dr Wendy Shallcross and Dr Lin Sweeney, Child and Adolescent Psychotherapists. Finally I wish to thank my partner Noel Dempsey for his unfailing belief and patience in me.

Introduction

This research takes a qualitative approach to interpret data about health visitors' experiences of working with infant mental health concerns with children under-five. Through the use of the Free Association Narrative Interview (FANI) and thematic analysis this study explores and analyses the subjective experiences of health visitors. This analysis informs understanding regarding how health visitors think about infant mental health concerns, their experiences of working with parent-infant relationships, what supports practice and the impact this work may have on health visitor wellbeing.

Throughout this study I routinely refer to health visitors and infant mental health, these terms will be shortened to HVs and IMH. I also use the term 'parent' to refer to a mother or father. The term 'mother' is used when using quotes, referring back to original quotations or when referring to issues around a mother giving birth. Where possible I have used the term 'primary caregiver' in order to remain gender neutral and to acknowledge adopters and foster carers.

In this introduction, the aims and objectives of the research are set out, along with the context around early intervention and the role of HVs in its delivery. This is followed by the origins and rationale for this study and a short reflection about my experiences of undertaking this research. Chapter one provides a literature review; beginning with an investigation into IMH difficulties and the parent-infant relationship. This is followed by an exploration of pertinent government policies and frameworks relating to HV practice and

early intervention. The second part of the literature review provides an overview of HV practice and current psychological and psychoanalytic theory to support understandings about unconscious processes affecting HV practice.

Chapter two provides an account of the methodology for this study, it describes how data was collected from five HVs interviewed using FANI and how transcripts were analysed using thematic analysis. The reader is taken through each stage of data analysis, beginning with coding and then how themes and categories were identified. Chapter three lists the findings, how these relate to the codes, themes, categories and how the categories interrelate. Chapter four, the discussion, brings together the findings with the literature, it reflects on the researcher's experience and chapter five, makes recommendations for practice and further research.

Research Aims and Objectives

This research asked the following question:

> **"What is the lived experience of health visitors working with the mental health of under-fives which is of concern?"**

The research objectives:

1. To explore and describe HVs' experiences of working with IMH, particularly when they are concerned about children under five.

2. To explore and describe how HVs manage their experiences/ reactions when working with IMH concerns.

3. To explore HVs' experiences of seeking help when addressing IMH concerns.

This research informs recommendations about how to enhance HV care of vulnerable families and the mental health of under-fives.

Context

For many years, research has been growing concerning the crucial period of early years development and the impact this has upon brain development and IMH. This evidence has been considered in various government policies, strategies and frameworks (House of Commons Health and Social Care Committee, 2019; HM Government, 2011-12; Public Health England, 2018; Cross–Party Manifesto,2013; Department of Health, 1999-2015; Marmot, M., 2010; Munro, E., 2011; Hogg, S. (2019). HVs support children's development through the first five-years of life, providing a range of health interventions and identifying when specialist referrals are required. They are at the forefront of early preventative intervention, providing the best early warning system (Balbernie, 2013) to prevent the development of behavioural and mental health problems in later childhood.

HVs are well versed in the physical development and monitoring of children under-five but emotional and psychological development is less straight forward; this requires observational skills and reflection on the parent-infant relationship. These skills are part of

the Solihull Approach training (Douglas, 2002), a brief early intervention and most HV where I work are trained in this approach.

Origins and Rationale

As a child and adolescent psychotherapist, this study is contextualised within the field of psychoanalysis and child development research (demonstrated in the literature review). However, this psychoanalytic perspective was put aside during data analysis to provide validity. The application of psychanalytic theory was valuable later in the study (in the discussion), to provide additional insight into the unconscious aspects of working with families in need. The rationale for this research stems from my attendance at an IMH conference held by the NHS Trust where I am employed. During the conference HVs told me they were passionate about their work but wanted more support in understanding IMH. The HVs also shared how they find themselves managing increasingly complex cases with expanding caseloads / responsibilities in the context of making less visits to families.

According to the Rare Jewels report (2019) there are now 27 specialist infant mental health services across the UK. In my local area there is no ongoing support for HVs working with IMH concerns. This may lead HVs to refer to other professionals, rather than feeling confident in their ability to provide short interventions. Furthermore, some HVs may only begin to consider IMH when there are safeguarding concerns. Currently, the Trust where I work has no specialist IMH service and children under-five are rarely accepted into specialist Child and Adolescent Mental Health Services (CAMHS).

Many professions and services are involved with supporting families and children, where IMH may be of concern; however, the focus of this study is HVs. An initial 'scoping' search for other research regarding HVs' experiences of working with IMH concerns revealed no results. There were some examples of research alongside the Solihull Approach but this focused on the HV response to the training or to consultation. This demonstrates how this research could contribute to a better understanding of HVs' experiences and their needs. This study may also be beneficial to other health professionals working in child mental health, as parallels may be drawn between experiences. Furthermore, other professionals reading this research may gain a clearer picture of how to draw on the skills and the unique relationships HVs foster with families.

Research Experience

Undertaking this research involved taking up a different role to that of a child psychotherapist; I needed to adopt a more scientific approach to identify a research question and choose a method that would allow me to answer the type of question posed. As a novice researcher this process required much support from my research supervisors. Initially I attempted to address complex research questions but the scope of the project became unmanageable within the timeframe, knowledge and skills I possessed. This led me to find a simpler question; however this simplicity did not detract from the meaningfulness and importance of exploring HVs' experiences of IMH concerns. Instead, this modest approach to the question provided a straightforward way into the research where I could begin to grapple with and take up the research process.

The interviewing process and taking up the researcher stance was also a learning curve but there were familiar elements, for example, not interpreting and remaining neutral, was reminiscent of Bick's advice when undertaking an infant observation (Bick, 1964). In the second interview I was able to address some inconsistencies and ask HVs to expand on themes. However, as the relationship developed I became more aware of unconscious projections that I was not able to address with the participant in my role as researcher.

Also familiar, was the notion of putting aside preconceptions, judgements and theories; this is a concept known as 'bracketing', originating from the work of phenomenological philosopher Husserl (1913/1931) and interpreted later by Merleau-Ponty (1962, 1968). The process of bracketing enables lived experiences, gathered from active seeing and describing, to be revealed. This is not dissimilar to Bion's (1965) approach to psychoanalysis where the analyst aims to set aside all memory and desire. Despite being familiar with this approach, it nonetheless was difficult, not only to hold back my thoughts during interviews but also any preconceptions I had when analysing data. During this study I learned to wait and defer responses and subjective opinions, by writing them in my field notes and separating them from the data analysis and returning to them after this process. I have gained skills in managing and systematically analysing data using thematic analysis. This process was hugely time consuming and required a considerable amount of patience.

Through interviews and analysis I became sensitive to the weight of the HV role and gained a better understanding of their responsibilities and challenges. This study informs understanding of HVs' experiences with IMH concerns and how the HV state of mind and their countertransference experiences, can be impacted upon by risk. HVs generally do not

receive psychoanalytic support to help them understand their experiences and this insight could inform recommendations for practice. This study also arouses further questions, for example, would other professions who work in mental health have similar experiences to HVs?

1 Literature Review

This chapter provides a review of literature in relation to infant mental health, the role of HVs and the potential impact this can have on HV practice. The first part of this chapter explains the strategies used to search for pertinent topics and the sources of information. This is followed by a brief account of infant mental health difficulties and a description of protective factors in early parent-infant relationships. This involves a review of; Winnicott's theories (1954, 1960) regarding the early phases of the parent-infant relationship; attachment theory (Bowlby, 1969); brain development in relation to the early relationship (Schore, 2001); key developmental processes, such as, containment (Bion, 1962b), reciprocity (Brazelton et al, 1975), agency, and the work of Fonagy (1989, 2006) concerning mentalization. Risk factors in regard to parental mental health are also explored.

Government policies, frameworks and 'aims for best practice' are reviewed; this is particularly in relation to safeguarding, early intervention and the key role HVs play in supporting families. The last part of this chapter is dedicated to exploring HVs, their training, how they prioritise families and the impact HV practice has on their wellbeing. To aid my understanding, I have explored theory around secondary trauma, psychoanalytic concepts and organisational processes.

1.1 Literature Review Strategy

The focus of this research is from birth to five. Searches were conducted using databases such as, 'PsychINFO' where searches containing key words of topics connected to the study

can be investigated. Results were expanded and reduced using Boolean operators, search yields refined with limiters and a history of searches saved in the database and organised in an Endnote account. An initial 'scoping' search revealed substantial literature regarding 'infant mental health' but when linked with 'health visitor' this only yielded four results. Two of these concerned the Solihull Approach, an evidence based intervention. There are several studies regarding the Solihull Approach, its efficacy and the benefits of running consultation groups. There are also many studies regarding practitioners' experiences of consultation about IMH and some specifically concerning HVs. However, no results included research regarding HVs' actual experience of working with IMH. This demonstrates how this research can contribute in a unique way to a better understanding HVs' experiences and needs: by listening to what HVs say about their practice, what works and what support they need. Other searches involved using google, google scholar and the discovery database on the Tavistock and Portman library website. These searches prompted finding papers in journals such as, Infant Mental Health Journal, Community Practitioner, Journal of Clinical Nursing and the International Journal of Psychoanalysis.

1.2   Perceptions of Infant Health Concerns

IMH difficulties can be expressed outwardly in many forms: feeding difficulties, restlessness, anxiety (separation anxiety), self-harming (biting, head-banging), risk taking, sleep disturbances, toileting issues and persistent crying. In 1994 the National Centre for Clinical Infant Programmes (Zero to Three) produced the 'Diagnostic classification of mental health and developmental disorders of infancy and early childhood'. Updated in 2016, the

disorders for children aged from birth to five include: Neuro developmental, sensory processing, anxiety, mood, obsessive compulsive, sleep, eating and crying, relationship disorders, trauma, stress and deprivation disorders.

The contemporary movement surrounding the 'First 1000 critical days of life' (2019) is educating society regarding the importance of infant mental health. However, from as early as 1946, in Spitz and Wolf's shocking paper, concerning a long-term study of infant behaviour in a nursery, infants were observed to become depressed from six-months-old. This paper describes infants' depression as weepy behaviour, a rigid expression and turning away from people and their surroundings. These behaviours could result in weight loss, insomnia, susceptibility to illness and developmental delay. They define the depression as anaclitic, meaning that it is related to a strong emotional dependence on another because it appeared to 'only' develop in 'some' infants. These infants were deprived of their love object for a practically unbroken period of three months during their first year of life (Spitz and Wolf, 1946). This work appears to have led the way for a contemporary understanding of IMH which concerns the emotional, physical, cognitive and social wellbeing of an infant.

Bick (1968) observed and wrote about infantile defences; she considered the baby's skin provides a way of "binding together parts of the personality not as yet differentiated from parts of the body" (Bick 1968, p. 114). In early life the infant must sometimes manage the absence of a containing object, usually the mother. To cope with these early anxieties the infant finds a way to hold themselves together by both protective and defensive means. Bick describes this thus:

"The need for a containing object would seem, in the infant unintegrated state, to produce a frantic search for an object – a light, a voice, a smell, or other sensual object – which can hold the attention and thereby be experienced, momentarily at least, as holding parts of the personality together." (Bick, 1968, *in Briggs, 2002*, p. 56)

This passive experience provides evidence of such an object and helps the baby cope but it is not a sign of psychological strength. If the infant becomes dependant on a second skin to provide a containing function and is unable to accept or receive containment, then the object can be replaced by infantile pseudo-independence.

Fraiberg (1982), observed infants as young as three-months-old, exhibiting pathological defences. In the course of her research she discovered infants, who had experienced extreme deprivation, develop defences against helplessness and intolerable anxiety. These infantile defences include: avoidance from the baby to the mother and vice versa, for example the baby looking away from the mother or not vocalising or smiling in response to her. In states of distress these babies 'scream into the wilderness' and when their pain reaches intolerable limits fall silent as if they have reached a cut-off in their capacity to express their distress: Freezing, of posture, articulation and mobility: Fighting, where fear vanishes from the infant's face but when the fight fails they are once again distressed: Transformations of affect, where anxiety provoking situations trigger laughter in the infant: Reversal, where infants aggression in response to the carer is turned on themselves, these children are able to tolerate high levels of pain.

In Field and Reite's 1984 study, mother-infant dyads were observed during and after a separation due to the mother's hospitalisation for the birth of a sibling. Data showed the infant displayed agitated behaviour and physiology during the period of separation and when reunited 'depressed behaviour and activity'. This suggested "the mother remained unavailable to the infant despite her physical presence; typically the mothers were tired, and some experienced postpartum depression" (1994, p. 215). Another study by Field (1984) titled, 'Early interactions between infants and their postpartum depressed mothers', found that an infant as young as three months can experience depressed affect in response to early interactions with their depressed mother.

1.3   The Parent Infant Relationship

Infants' wellbeing is strongly connected to the primary carer relationship, set in the context of family relationships and their environment. Winnicott (1960) highlighted the delicate balance in the relationship between the caregiver and their baby. Initially the mother needs to identify with her baby and in this way she innately understands her baby's needs through the mechanism of projective identification. In her devotion the mother 'behaves reliably' and provides a 'holding' environment (psychological) which initially is a physiological one adapting to the baby's needs.

In healthy early relationships, 'graduated failure of adaption' is a maternal function (Winnicott, 1954) and as the infant needs to separate, the mother's identification (if she is not distorted in these matters) gradually loses significance. The baby's adaption to reality

allows the personality to begin to be gathered together externally and internally. However, failure of the mother to adapt contingently with her baby means the baby must react and reacting interrupts 'continuity of being' (Winnicott, 1954). Furthermore, if the mother is too good she impedes the baby's process of moving to become separate; if she is not good enough the baby's illusion is shattered too soon exposing the baby to primitive anxieties, relating to the threat of annihilation.

Winnicott's (1954) idea of the harmful effects of 'too good mothering' was taken up by Hopkins (1996). Hopkins' observations, using the Bick method (1964), underline the perils of a mother's over adaptation to her baby. The 'too good mother' magically anticipates her baby's desires and frustrations through over identification, where she meets these needs as if they were her own. This over identification continues long after the initial period that is helpful to the baby. In attempting to spare the baby any distress the mother makes herself indispensable, giving the baby little space to discover their own needs and desires, separately. This denies the infant the opportunity for giving and making reparation, affecting development. In particular the baby's sense of agency and capacity for concern (to feel and learn to manage guilt), are impaired. Winnicott (1960) suggests the outcome would be that the mother is rejected or there is a continued state of merging.

Containment

An essential part of the parent-infant relationship is the parents' capacity to receive and understand a baby's emotional cues, such as when they become overwhelmed. Bion (1962b) called this containment. Within the structure of containment is the oscillation between two positions of anxiety (Klein, 1935), the paranoid schizoid position and the

depressive position. The paranoid schizoid position is concerned with part object relating and the splitting of complex feelings into binary feelings of good and bad. The depressive position concerns whole object relating and coming to terms with painful realities, allowing for the integration of love and hate, accompanied by sadness and a wish to repair. Bion, instead of focusing on stages of development where the personality progresses through to maturity, was interested in the constant fluctuation between the two positions throughout the stages of development, identified with the symbol Ps↔D (Bion, 1963).

Containment is possible when the primary carer's mind is available to introject the infant's projections and give them meaning. Bion called this state of mind maternal reverie (1962a); the mother's love allows her to tolerate the to and fro between Ps↔D. In finding the depressive position the mother can then transform beta elements, those parts the infant expelled to defend against fear of perceived persecuting objects, into alpha elements, making sense of the infant's feeling of 'dread'.

Bion (1962b) referred to this primitive form of communication as projective identification. This containing experience, when done repeatedly, gives the infant an experience that feelings can be modified into something known and tolerable. It allows introjection and identification with a thinking mother/primary carer, enabling the infant to build an internal sense of good objects. This is famously referred to by Bion as the 'container / contained' (Bion, 1962b). However, without enough contact with good objects the baby's relationships become persecuting and threatening. If the baby's attacks cannot be introjected by a containing object then the external object becomes hostile, making normal development impossible and a state of mind that can become destructive of all links (Bion, 1959).

Furthermore, if projective identification is used excessively, without containment, the relationship can become confused. Klein provides a valuable explanation of this in the following quote:

"When things go wrong, excessive projective identification, by which split-off parts of the self are projected into the object, leads to a strong confusion between self and the object, which also comes to stand for the self. Bound up with this is a weakening of the ego and grave disturbance in object relations." (Klein, 1957, p. 192)

The concept of the 'container contained' is essential when considering children and parents and it is logical to assume that in order for a parent to contain they must at first themselves feel contained. This is in part the role of a HV, as they often become containing parents "in relation to the parents' own personal issues, feelings and emotions" (Astbury et al., 2016, p. 221).

Attachment

Bowlby (1969) investigated babies' biological need for a protective figure and that the capacity of the infant to form close and secure relationships evolves out of attachment to the primary carer. A secure attachment requires a secure base of trust and safety through a dependable carer, in a facilitating environment, where an infant is free to explore. However, if the parental relationship does not offer a secure base this causes psychological difficulties in the growing child. This secure base supports how "…infants develop emotion regulation, or become behaviourally and physiologically organized, in the context of early

mother-infant interactions" (Field, 1994, p. 209). Attachment theory is relevant to HVs as they routinely use the language of attachment (Balbernie, 2013) to support their work with the parent-infant relationship (and is mentioned in the healthy child programme).

Later, Ainsworth (1978) in her 'strange situation' test, discovered that different parenting styles influence children's patterns of relating. These styles were categorised into three main types: securely attached, linking to sensitive and responsive parents. The insecure attachment styles include; 'avoidant', where infants' self-soothe/regulate their distress. Parents of these children are less responsive to their child's emotional needs. 'Ambivalent', where infants are pre-occupied and clingy, the carers of these children are inconsistent in their responses to the child. A fourth type of attachment style was discovered by Hesse and Main (2000), these children showed more worrying signs of distress such as, hurting themselves, bizarre behaviours and 'freezing.' These children had experiences of unpredictable and traumatising parenting.

Brain Development

Infants early relationships impact upon brain development, advances in neuroscience tell us brains do not automatically develop but have 'potential' triggered by loving interactions (Gerhardt, 2004). Gerhardt explains that through the mother's face-to-face interaction, touch and tone of voice, infants are able to reference from their expression and gain meaning. Infants learn to manage stress with the support of an empathic attachment figure and these early experiences become inscribed into brain pathways. Experiences and environments dictate which connections get more use, the more neural pathways are used, the more efficient and stronger they become. Furthermore, good encounters lead to the

release of useful chemicals such as, oxytocin that reduce the impact of stress and boost the immune system assisting with the development of trusting relationships.

Schore (2001) suggests that early infant relational trauma, where stress is exacerbated by attachment figures, contributes to right brain dysfunction which is linked to emotional dysregulation.

> "During its critical period of maturation in the first two years, prolonged episodes of intense and unregulated interactive traumatic stress induce not only heightened negative affect, but chaotic biochemical alterations that produce a developmentally immature, structurally defective right brain." (Schore, 2001, p. 237)

These biochemical alterations create toxic stress, this is in part due to increased levels of cortisol which inhibit behaviour and cause dissociative responses. The infants' maladaptive strategy, to cope with stress, results in the body being on permanent alert. The system becomes overloaded affecting neurobiological development and neuro pathways become weaker and fewer. These changes impact upon the ability to learn, concentrate, reason and manage strong emotions (Gerhardt, 2004).

Brain function is also connected to our ability to read others emotions, Rizzolatti (2005) discovered mirror neurons, where the same neuron fires up in someone, by just witnessing an action performed by another person. The intersubjective relationship (Trevarthen, 1998) combined with the development of the brain provides the infant with expectations about relationships, this helps the infant develop expectations of how interactions will be and as a

result, the infant creates an internal working model of representations of self and others (Music, 2011).

Reciprocity

Reciprocity concerns the ability of parent and infant to build a mutually satisfying relationship. Reciprocity is a concept coined by Brazelton et al. (1974), where trends were identified in the parent and baby cycle of attention. In synchronous interactions the adult and baby initiate, regulate and terminate their shared attention. Brazelton et al. (1975) showed that in the initiation phase there is acceleration in positive behaviours, such as, smiling and vocalising matched in the interaction between adult and baby until it reaches the peak of excitement. Following this peak, there is deceleration where the adult takes their cue from the baby and there is a decrease in behaviours. The cycle is complete when the baby turns away and withdraws.

Sometimes, there is a rupture in this reciprocal dance and the infant's cue is not understood. Tronick (2007) found that even the best mother-infant dyads misread their baby's cues, roughly 30 percent of the time. What becomes essential here is how the mother adjusts and repairs to allow the dance to get back into step. This repair in fact strengthens the baby's independence to cope with life's inevitable vicissitudes.

Secure attachments are based on parents' capacity to sensitively read their babies cues for when they need attention or withdrawal (Isabella and Belsky, 1991). From reciprocal relationships infants begin to understand words and share experience or joint attention with the same object in mind at one time. Reciprocity and early relationships help build

resilience (Osofsky and Thompson, 2012) allowing the infant to move towards the ability to understand the wishes and intentions of somebody other than themselves. This concept is called theory of mind and is demonstrated within the first year by the infant being able to be self-conscious, seek praise, mimic, and get others to react (Music, 2011). It allows the baby to have an interpersonal representation of themselves seen through the eyes of another and reflect on their own and others mental states. This mind-mindfulness helps infants understand the beliefs and feelings of others and develop empathy and a sense of agency.

Agency

In the development of physical and social agency an infant discovers, "that a contingency exists between his own activity and the occurrence of external events" (Broucek, 1979, p. 311). This is beautifully evidenced with Papousek's 'switching on experiments' (1975); in the experiment with four-month-old infants, the baby responds with joy when they realise that they can turn a light on and off with a movement. Furthermore, it was discovered that the event itself does not produce a reward but that the infant finds value in their actions having an effect (Papousek, 1975). Broucek concludes:

> "…it seems inescapable that the infant's pleasure in this situation is pleasure in being the cause. This sense of efficacy and the pleasure associated with it are in my opinion the foundation of self-feeling." (Broucek, 1979, p. 312)

The sense of efficacy and influence includes the ability to understand and predict environmental events. However, if this is threatened the infant may choose to ignore these aspects of the environment with 'active avoidance and passive unresponsiveness.' Broucek

suggests that if infants are confronted with too many insolvable problems or too many unpredictable disturbances in the continuity or consistency of maternal care they may fail to develop a strong sense of efficacy and influence.

Mentalization

Secure attachments are rooted in the quality of early object relations and are the foundation of mentalizing. The term mentalization was first used by Fonagy (1989) and concerns the ability to hold other persons 'minds in mind' or to understand or interpret one's own and others mental states. Similar to Bion's (1962b) concept of containment, the process of mentalization requires infant states to be adequately understood by caring attentive and non-threatening adults. Mentalization is a form of emotional knowing; it is suffused with emotion and concerns thinking about feelings in one self and others (Allen, 2006).

Connected to theory of mind, mentalizing enhances agency and our capacity to influence others (Bandura, 2001). Having a sense of self is anchored in having an emotional sense of the self (Damasio, 1999; Stern, 2004) and is intertwined with agency 'a feeling of doing' (Marcel, 2003) or the capacity to initiate action for purpose (Allen, 2006). Adverse childhood experiences, such as, trauma in attachment relationships or major depressive episodes, undermine the development of mentalizing. In a non-mentalizing mode we can become emotionally detached which can lead to escalating emotions and an inability to accurately understand others.

Mentalization provides structure to scaffold experiences from one activity (or state of mind) to the next, providing 'continuity of being' (Winnicott, 1954). Containment (Bion, 1962b) and mentalization overlap, there is not a clear distinction between the two but Bion's concept of containment is more concerned with unconscious processes.

1.4   The Parent Infant Relationship – Risk Factors

Parental Mental Health

Other etiological factors contributing to poor parent-infant relationships impacting on IMH are, socio-economic deprivation and environmental stressors such as parental mental health. The birth of a baby can be a stressful period and awaken difficulties in parents' personalities or traumatic experiences from the past and these may become reflected in the relationship with the baby. Mothers in the perinatal period are more likely than in other time of their life to develop their first affective disorder (Oats, 2000). The prevalence of new mothers developing postnatal depression (PND) is 10-20% (Seeley et al., 1996; Yonkers et al., 2001; Peindl, 2005) and 10% of new Fathers develop PND (Madson and Juhl, 2007).

The symptoms of postnatal depression are similar to that of depression but with the additional complication of the impact of the mother's depression on her baby. Some mothers struggle to bond, they feel detached and have thoughts of wanting to harm themselves or the baby, but this is rarely acted upon. PND affects parent-child interactions, impacting on the care-giver's capacity to pick up on the baby's cues (Cooper and Murray, 1997). In these circumstances evidence suggests the infant has a higher rate of insecure

attachment and impaired emotional and cognitive development, sometimes continuing well into school age (Murray, 2000; Murray and Cooper, 1996).

Fathers can play an important role in providing support for the mother to enable her to support the baby and "evidence suggests that fathers are biologically no less sensitive potentially to infant signals than mothers" (Music, 2011, p. 175). Furthermore, 'A secure attachment with a father can offset an insecure one with a mother and vice versa' (Music, 2011, p. 181). Research also suggests children fare worse when they are raised by a lone parent but studies have shown this can be linked to income and social disadvantage (Spencer, 2005).

A mother, who has an existing mental health problem or has developed a mental health problem in pregnancy or in the first year following birth, can be referred to perinatal services. Outside of this service, it becomes the role of HVs to identify PND, this can be difficult because parents may say they are 'fine'. Furthermore, there is the added complication of stigma around mental health, making seeking support problematic (Abrams and Curran, 2011) along with the fear of being labelled an unfit parent.

HVs treat PND by giving more intensive support (Rothman, 2006), listening and providing advice, guidance and empathy. HVs also use their observational skills, such as, looking at mother and baby interactions and helping parents respond to babies' cues. Once in recovery, HVs assist the mother to access parenting groups, infant massage and mother-toddler groups. Inevitably some women will require more specialist support but the majority are treated in primary care (DH, 1999).

Generational Trauma

In the seminal paper 'Ghosts in the nursery' (1975), Fraiberg and her colleagues use this metaphor to illustrate the 'unremembered ghosts or unwanted guests' of parents' past childhood. These intruders sometimes emerge after several generations and become unconsciously reawakened in the minds of parents. Past difficulties or trauma can then be repeated and re-enacted in the present with their own babies. However, in favourable circumstances "the bonds of love protect the child" (Fraiberg et al., 1975, p. 387) and parents from any intrusions that may break through into the present relationship. In less favourable circumstances, parents unconsciously defend against the affect accompanying their past childhood trauma. The memory of the trauma may be present but the feeling alongside is repressed. This provides 'motive and energy for repetition' allowing "ghosts of the parental past to take possession of the nursery" (Fraiberg et al., 1975, p. 419) and depending on a parent's particular vulnerabilities, impact on the baby's physical and emotional development.

Fraiberg explains, how "a pathological identification with the dangerous and assaultive enemies of the ego" (Fraiberg et al., 1975, p. 419) can make it difficult for parents to make links with their own experience of being parented. Subsequently, some parents struggle to seek help because the people trying to offer support may themselves be perceived as the 'intruders.' Fraiberg describes how the therapeutic process of remembering 'affect' illuminates the past in the present, allowing the parent to identify with their own injured child self instead of past fearsome figures. In the course of visiting families HVs may well be

familiar with the Ghosts in the nursery. Fraiberg's paper brings into focus generational trauma, how this can be unconsciously passed down and the importance of understanding family history and the impact this can have on a baby.

1.5   Government Frameworks for Safeguarding and Early Intervention

HV practice in regards to early intervention is guided by several national and local government policies, strategies and frameworks. These documents include safeguarding processes, recognition of the effectiveness of early intervention, commitment to tackling inequalities in outcomes for children and shape the tasks and role of HVs in their work with IMH. Some of the most pertinent documents will be described in chronological order.

Every Child Matters (DH, 2003)

In 2003 'Every child matters' was produced by the Department of Health, it provides a detailed framework supporting change to improve the wellbeing of young people under 19 years. The framework recognises the risk around deprived socio-economic groups and how children can be affected by their early environment. It highlights the importance of accessible joined up/ integrated services and seeks to optimise diverse skills to enable information to be shared about children to create the best outcomes. This strategy looks at ways HVs, along with other community services, can support families in greatest need and help develop parents' understanding of how to help their child's development.

The National Services Framework (DH, 2004)

'Every child matters' was followed by 'The national services framework' (2004), this framework set the standards for children's health and social care. Once again the role of

HVs is invaluable for intervening early to assess and review children's progress from conception onwards, ensuring health and development needs are addressed by advising parents. This involves working with early years staff to raise awareness and provide a referral point for further assessment and for children with developmental delay to receive early intervention by a range of health, education and social care professionals.

The Healthy Child Programme (DH, 2009)

The main tasks of health visiting are expounded in the Healthy Child Programme (HCP), written by the Department of Health (2009). The HCP is an early intervention and prevention, public health programme, lying at the heart of all universal services for children and families. The programme provides an evidence-base of health interventions, beginning in pregnancy and continuing throughout childhood. Led and delivered by HVs, the programme depends on co-ordination of multi-agency activity for children and families and integrated working across the health service (primary healthcare teams) and the wider children's workforce (Sure Start children's centres).

The HCP takes a pro-active role in promoting the optimal physical, social and emotional development of children by offering every family; screening tests, immunisations, developmental reviews, and information and guidance to support parenting and healthy choices. Most importantly, in terms of this research, the HCP emphasises parent support, stressing the importance of attachment and how to maintain IMH by focusing on the impact of early nurturing environments. The programme identifies the Solihull Approach (Douglas, 2002) a specialist training to support understanding of IMH and work with families. The HCP also highlights how HVs identify and provide interventions for maternal depression.

The guidance for Health Visitors includes, advice regarding how to avoid a "tick box approach" (DH, p. 20) and that listening well, observing carefully, understanding when things are going wrong and being able to deal with this sensitively, are crucial to the role. According to regulations in England (Public Health England, 2018), all families and babies should receive five Health visitor checks from birth to two-and-a-half years-of-age.

Reviews

There are also reviews offering guidelines relevant for HVs; the Marmot review (2010) highlights social inequalities, stating the lower a person's social position the worse his or her health. Therefore, in order to give every child the best start in life this needs to be reduced. The Munro review (2011) asserts children and young people are not sufficiently heard and that there is a lack of continuity in relationships with professionals. Furthermore, bureaucratic process focussed more on cases of serious abuse, leading to insufficient preventative early help for those considered to be less serious. The review set out reform proposals to enable professionals to make the best judgement for children and emphasises the vital role for universal services and working together.

Another review commissioned by the government is 'Early Intervention the next steps' (HM Government, 2011), this sets out the rationale for early intervention, including the importance of child development and maternal mental health. The document warns that late intervention is costly and ineffective. It called for cross party co-operation to create social and emotional bedrocks for children and made recommendations to support the provision of the most effective early interventions.   Staff policies and infrastructure were

reviewed and programmes identified which promote early intervention. Furthermore, the report suggests the interventions should follow best methodology and science, using data and measuring tools to identify those in need.

National Institute for Clinical Excellence

The National Institute for Clinical Excellence has also produced recommendations and guidelines for 'Social and Emotional Wellbeing: early years' (2012). It states under-fives will be supported through home visiting, childcare and early education. It recommends HVs identify vulnerable children and factors that pose a risk to children's social and emotional wellbeing. It states HVs should refer to specialist services when necessary and to provide targeted services and evidence based structured interventions, such as baby massage or Video Interaction Guidance. The guidance emphasises the importance of involving parents, other family members and participation in community services. Also in this document is the recommendation from the Public Interventions Advisory Committee pointing to the strong economic case for preventative services which requires HV workforce expansion.

Future in Mind (DH, 2015)

A more recent strategy from the Department of Health is 'Future in mind' (2015) jointly produced with NHS England. This document arose from an earlier report from the government about CAMHS services in 2013-14 highlighting that children's mental health services were in 'chaos'. Future in mind, seeks to promote, protect and improve children's wellbeing and provide strategies on how to improve services and provision. It again details the importance of early intervention, prevention, promoting resilience and having access to specialist support. The strategy highlights that within universal services HVs not only

provide health promotion and prevention but a support network. 'Future in mind' emphasises the need for integrated, specialist and targeted mental health services at a single point of access. The plan seeks to improve early support for parents, carers and children from birth and identified that HV need to update their training around mental health.

1001 Critical Days (2013)

The 1001 critical days cross party manifesto, highlighted the importance of the conception to age two period and called for a radical change in how we approach these critical days. This was followed by the 'First 1000 days of life' report in 2019 which has set out an ambitious cross government strategy for a co-ordinated long-term response to improve support for children, parents and families nationally and locally. The report recognises the first 1000 days as a "critical phase during which the foundations of a child's development are laid," (2019, p. 3) and proposes services should be founded on six principles:

- "Proportionate universalism", so services are available to all and targeted in proportion to the level of need,
- Prevention and early intervention,
- Community partnerships,
- A focus on meeting the needs of marginalised groups,
- Greater integration and better multi-agency working; and
- Evidence-based provision.

The Healthy Child Programme is at the centre of universal and targeted services and the report recommended an enhanced programme, beginning at conception and for home-visits to be extended beyond the age of two-and-a-half. In addition, HVs are encouraged to focus

on the whole family and for there to be improved continuity of care to support staff in building relationships with families.

Following on from the 'First 1000 critical days of life' in the same year the 'Rare Jewels report' (2019) was published by Parent Infant partnership UK. The report recognises the specialist skilled expertise necessary to enable truly preventative work. It makes a case for more specialist parent-infant relationship teams to offer local systems, providing effective high quality early intervention. Currently there are only 27 teams in the UK, hence the title, 'rare jewels'.

To sum up the review of policies in relation to HV and IMH, several of the documents repeat similar messages. They all call for services to be integrated and for there to be proactive services delivering early intervention and prevention. This is along with targeted support for the families who need it most.

1.6   Health Visiting

HVs take a healthy, pragmatic and flexible approach to work in partnership with parents and children. Relationship building and communication is an established core feature of health visiting (Appleton and Cowley, 2008) along with intuition which is a source of knowledge for nurses (Benner, 1984). These skills are key in making headway with families under pressure who may experience stressors such as, poor environment, domestic violence and parental physical and mental health problems.

Health visiting has fallen in and out of favour with government spending. In 2011, the health visiting implementation plan was published which provided a huge boost to fund and train extra HVs. However, since 'austerity', health visiting services have experienced huge changes (funding responsibility for most public health services moved from health and social care Vijayshankar, 2018) while also being massively cut (Scott 2019). An article called 'Shining a Light' in Community practitioner 2019, reflected on the impact of these cuts. The article, based on HV views, found increased HV caseloads and work stress, down banding of HVs, role change, capacity issues, difficulties in staff recruitment and retention, leading to low morale in the profession and burnout (Scott, 2019). The impact of these strains has meant a 24% decline in the number of health visitors between October 2015 and June 2018, translating to a loss of 2399 health visitors.

History

Health visiting developed in the 19th and early 20th century as a response to adverse living conditions, relating to poor hygiene and sanitation; these problems significantly affected the life expectancy in the labouring population (While, 1987). Health visiting began in the voluntary sector, 'middle class women' would visit from house to house distributing leaflets, teaching hygiene, child welfare, providing social support (sometimes giving food and clothing), teaching on moral and mental health issues and if children were sick made referrals to doctors. Health visiting was legislated by the government following the formation of the National Health Service and became an established statutory provision (While, 1987).

Training

To train as a health visitor or Specialist Community Public Health Nurse (SCPHN), the applicant must already be a registered nurse or midwife. Further specialist training consists of a one-year (full-time) training in family and community health. Health Visiting is governed by the 'Institute of Health Visiting' and health visiting practice is implemented by using four enduring processes, known as the 'principles of health visiting,' (Accessed: 2019). These are: The search for health needs: The stimulation of an awareness of health needs: The influence on policies affecting health: The facilitation of health-enhancing activities (Nursing and Midwifery Council, 2015).

The Solihull Approach (Douglas, 2002) was developed in response to a need for additional specialist training to support parent-infant relationships with brief early intervention. The training takes into account reduced access to CAMHS services and seeks to provide a unified shared language between HVs, psychology and Child psychotherapy to promote IMH and make it everyone's business. It is a theoretical model designed by child psychologist and psychotherapist, Hazel Douglas and draws on a wealth of literature from child development research. The Solihull Approach uses established theories from psychology and child psychotherapy psychodynamic / behavioural models. It promotes observing parent-child interactions and at its core are concepts of containment, reciprocity and behaviour management. Alongside the theoretical model the training provides insight into why reflective practice is essential to supporting HVs.

Prioritising need

Along with all people who come into contact with children, HVs use frameworks to assess and identify vulnerabilities and level of need. Each local authority has their own tools to measure thresholds of need. Many have adopted the continuation of care, or the windscreen, to prioritise and develop levels of support and intervention matched to the needs and strengths of the child and the family. This framework also helps to inform when safeguarding measures need to be undertaken.
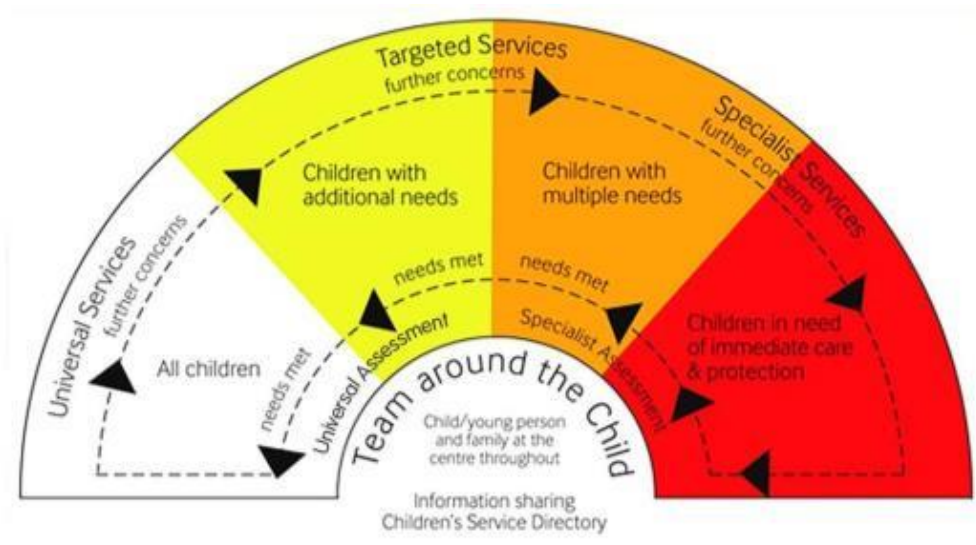
Figure 1: Continuity of Care

Under the new HV model there are four levels of service: 1) in the community, this concerns the services families and communities provide themselves. HVs work to develop these services and ensure families know about what is available. 2) Universal Services, concerns the implementation of the HCP. 3) Universal Plus (UP), HVs provide a rapid response to families who need more expert help, for example with post-natal depression, sleepless babies or parenting concerns. 4) Universal Partnership Plus (UPP), HVs provide ongoing support over a period of time for complex cases which need partnership working across agencies (HM Government, 2012).

As HV policy changes so does how HVs assess risk, this is the subject of a paper called 'sticking to carpets' by Caroline King research associate (2016). The paper highlights the result of a shift from universal services to more targeted support and how this is re-shaping HV practice with an increased emphasis on risk. The title of the paper links to how HVs described their responses to visiting families who live in 'absolute filth'. The research explores the tension between using assessment tools to measure risk, which on the one hand provides HVs with structure and evidence but produces more of a discourse around risk. This is opposed to HVs using their judgement which can be subjective and impacted on by class and notions of ideal parenting. Both seem to be at the expense of attending to the impact of risk rather than their judgement of risk.

Reflective Practice

Increasingly there has been a move to providing reflective practice for practitioners working in the area of IMH. Stephanopoulo et al. (2011, p. 11), found that HV reported "…regular consultation and containment for staff was crucial to support them in their increasingly demanding work undertaken with families." Early intervention work evokes strong emotions for interventionists and the families they serve (Brotherson et al., 2010). The aim of reflective practice is to encourage practitioners to step back, gain greater insight into the impact of interactions in work with families and to understand the caregivers' emotional responses to the infant alongside their own (Gilkerson and Ritzler, 2005; Neilsen Gatti, Watson, and Siegel, 2011; Weatherston, Weigand, and Weigand, 2010).

Reflective practice helps safeguard against burnout and provides ongoing professional development to support the integration of knowledge. The goal of reflective practice is to

provide improved efficacy and interventions based on a better understanding of the family's needs. Evidence suggests practitioners should have access to supervision with a non-managerial figure who can attend to their emotional wellbeing (Ruch, 2008). Furthermore, research showed HVs preferred an outside consultant, feeling this would provide them with protected time and a focus on reflection (Watson and Neilsen Gatti, 2012).

1.7 Health Visitor Stressors

1.7.1 Secondary Trauma

Health Visitors are regularly exposed to trauma and distress, this may be when working with parents who have had traumatic childhoods or with families in desperate situations who continue to be affected by trauma (domestic violence) or distress (economic deprivation or social problems). HVs may also witness child neglect/abuse or the impact of maternal depression upon infants and children. Part of being a HV requires being empathic but this can be emotionally draining, sometimes with little reward. Janoff-Bulman (1985) suggests these experiences shatter three basic assumptions held by practitioners, a sense of invulnerability, believing in a meaningful world and positive self-perceptions. This can potentially disrupt experiences of safety, trust, power, esteem, intimacy, independence, and control (Pearlman and Saakvitne, 1995). These vulnerabilities make practitioners susceptible to secondary trauma.

Secondary trauma is now a widely recognised phenomenon and concerns the negative psychological effect of indirect exposure to traumatic material upon the helping professions

wishing to support people in distress. According to Trauma specialist Figley (2002), the symptoms of secondary trauma are almost identical to those associated with Post Traumatic Stress Disorder (PTSD); the only difference is that the PTSD symptoms are directly related to the sufferer and secondary trauma symptoms are as a result of "…exposure to knowledge about the traumatizing event" (2002, p. 1435). The symptoms of secondary trauma include anxiety, disconnection (isolation), avoidance of social contact, becoming judgmental, depression, somatization and disrupted beliefs about self and others (Pearlman and Saakvitne, 1995). This can result in downplaying difficulties, hypervigilance, guilt, finding it hard to concentrate or listen and difficulties managing boundaries between work and home life (Alberta Council of Women's Shelters, 2009).

Secondary trauma impacts emotionally, cognitively and behaviourally (Bride, Radey, and Figley, 2007), taking its toll on the psychological resilience of the 'helper'. Practitioners are more susceptible to secondary trauma if they have their own unresolved trauma (Blank, 1987) or repeatedly witness work related trauma. Secondary trauma is also associated more with practitioners who support those with mental health needs (Kuroda and Katon, 2004).

The concept of secondary trauma (Figley, 1993) is used interchangeably with several other terms, such as compassion fatigue. McCann and Pearlman (1990) used the term 'vicarious trauma', their work focused upon investigating the inner psychological effects upon 'helpers' experiences or countertransference reactions in response to repeated empathic engagement with traumatised people. "Countertransference is the 'state of mind in which other people's feelings are experienced as one's own" (Halton, 1994, p. 16). However,

despite the benefits of countertransference offering insight into victim trauma, McCann, Pearman and Figley all highlight the danger of countertransference responses. Countertransference responses can potentially encourage an over identification with victims, in some cases this may be with the perpetrators (Herman, 1981) or of meeting their own needs through the client (Corey, 1991). Therefore, countertransference sometimes has less to do with empathy concerning client trauma (Figley, 2002) and more about the therapists 'pre-existing personal characteristics' their response becoming "a function of his or her previously unresolved psychological conflicts" (McCann and Pearlman, 1990 p. 136).

Also connected to secondary trauma is 'burnout' defined by Maslach (1982) as "a syndrome of emotional exhaustion, depersonalization, and reduced personal accomplishment" (1982, p. 3). Burnout is considered a symptom of secondary trauma but not the cause and is likely the result of a culmination of work pressures. McCann and Pearlman (1990) suggest burnout symptomology includes, helplessness, emotional exhaustion, feeling ineffective and "may be analogous to the trauma survivor's numbing and avoidance patterns in that each reflects an inability to process traumatic material" (1990, p. 134). A solution to burnout may require a career change, unlike compassion fatigue which has a faster onset and is treatable if recognised and acted upon (Figley, 2002).

At the opposite end of the spectrum of health professionals' experiences of dealing with trauma is compassion satisfaction (Stamm, 2005). This concerns practitioners' experiences of gaining a sense of agency and pleasure or satisfaction from effectively treating those in need. The relationship between the three variables of compassion satisfaction, burnout and

compassion fatigue have been studied by Craig and Sprang (2010) and used to examine the quality of work life in a sample of health professionals.

There are several ways to protect practitioners from secondary trauma; firstly to recognise signs, monitor symptoms and support practitioners to separate themselves emotionally (Figley, 2002). It is also important to provide practitioners with opportunities to reflect on trauma and have it acknowledged. Other protective factors include specialist training, healthy working environments, receiving timely support and having autonomy and control (Ortlepp and Friedman, 2002). HVs also benefit from clearly defined roles and specialised training to manage their scope of practice (Ammerman et al., 2014). The importance of role is expanded on thus.

> "An inconsistent role standard can lead to role identity fragmentation and conflict across a group. It may precipitate individual role crisis, affecting optimum role performance." (Machin and Pearson, 2011, p. 1526)

Exposing factors to secondary trauma include, long hours, high caseloads, excessive stress levels and the work exceeding the resources of the practitioner. Several of these issues have already been highlighted as current problems faced by HVs at the beginning of this section.

1.7.2   Psychoanalytic Understanding of Systems and Organisations

This research is framed within the field of child psychotherapy and as such is set in the context of my role as child psychotherapist. Psychoanalytic concepts are integral to the

FANI method chosen for this study. However, these concepts also provide a way of understanding the unconscious impact upon HVs in the course of undertaking their work and how defences may be used to manage distress and anxiety in their interactions with families and their understanding of family dynamics. Furthermore, following analysis of the data, psychoanalytic concepts will be applied to the findings in the discussion.

Psychoanalytic processes can also be applied to how we think about systems and organisations and the impact this has on the staff working in them. Organisations have an unconscious life which can be studied psychoanalytically (Halton, 1994). Working in an institution can make it more difficult to understand processes because one may become caught up with anxieties inherent in the work and subsequently defend against those anxieties (Mosse, 1994). Some defences against anxiety and avoidance of pain are healthy and enable staff to cope but defences such as, denial can "obstruct contact with reality' and hinder tasks" (Mosse, 1994, p. 12).

An organisation may use the mechanism of projective identification, where the recipient of the projection reacts as if their own feelings are affected, essentially identifying with the projected feeling which may lead to acting out or splitting (Halton, 1994). Halton provides an example of how projective identification can become enacted in institutions:

> "…the client group can be regarded as the originator of the projections with the staff group as the recipients. The staff group may come to represent different, and possibly conflicting, emotional aspects of the psychological state of the client group." (Halton, 1994, p. 14)

If the staff group are supported to think about anxieties in the organisation, previously attributed to others, these can then be reflected upon, fears contained and a shift made to the depressive position (Halton, 1994).

1.7.3   Summary

The literature review found an enormous amount of literature and research around infant development, the importance of the parent-infant relationship and early intervention. There was also plenty of literature relating to HV policies, HV research concerning risk / public health and frameworks around IMH. The Solihull Approach research appeared to provide the only real tangible link between HV and psychoanalytic thinking. However, this did not take up understanding HVs' experiences of organisational dynamics and how this may impact upon their work. Furthermore, there was very little regarding HVs' experiences of working with maladaptive infant mental health, the literature tending to focus upon HV management of safeguarding. Also, literature regarding secondary trauma concerned generic health professionals and did not directly refer to HVs.

2   Research Methods

This chapter begins with the rationale for choosing qualitative research to describe HV experiences' regarding IMH of concern.   The research design and analytical strategy are outlined in two parts, 1) data collection method, and 2) data analysis method.   In data collection, the Free Association Narrative Interview (FANI) method is described, along with an understanding of why this approach was employed. This is followed by an account of the setting, how participants were identified, the interview questions, how data was collected and ethical considerations.   In the second part of this chapter, data analysis, the process of choosing thematic analysis is explained along with a description of thematic analysis and the stages of its application.

2.1   Method

This research required a research design that describes, interprets and explores experiences. This is best conducted using a qualitative approach, which relies on words and narratives. Strauss and Corbin say, "qualitative research allows researchers to get at the inner experiences of participants, to determine how meanings are formed through and in culture, and to discover rather than test variables" (2008, p. 13). A qualitative approach suits this study as it provides creative and flexible ways to understand experience where little is known, as opposed to finding facts through statistical analysis used in quantitative approaches.

I investigated several different methods for this research, such as, grounded theory, (Glasser

and Strauss, 1967) which is "grounded in data from participants who have experienced the process" (Creswell, 2013, p. 83). It is concerned with the generation of new theory concerning basic social processes studied in context and finding logically deduced hypotheses. I also considered Interpretive Phenomenological Analysis (Smith, 1996), partly because the phrase 'lived experience' is in the research question. This method places experience at the heart of the data by investigating how participants relate to the world and understand their lived experience.

The aim of this research was to extract data from HVs about their own specific experiences in relation to the topic and then analyse this data. Therefore, an important consideration was how data should be collected. I decided this would best be conducted through the use of semi-structured interviews. However, semi-structures interviews are not always a reliable method of obtaining *authentic* data because the researcher relies on the honesty of participants. This could be particularly difficult for professionals who may unconsciously defend themselves and their practice against less desirable emotional aspects of their work. Therefore, I searched for a suitable interview method that could support understanding unconscious defences.

Hollway and Jefferson (2000), take up these complexities in their Free Association Narrative Interview (FANI). They identify that the subject may be invested in a particular position to protect vulnerable parts of the self and support their preferred identity, they refer to this as a 'defended subject'. They therefore suggest a psychoanalytical approach to collecting data from interviews, this supports the analysis of less defended unconscious material. FANI enables participants to move beyond what was knowingly given to the interviewer.

Hollway and Jefferson advocate the use of psychoanalytic concepts, such as counter-transference, Klein's theory of splitting (1946) and Bion's theory of containment (1962b). In doing this, the researcher becomes a "product of the relationship" (Hollway and Jefferson, 2000, p. 41). As researchers "we cannot be detached but must examine our subjective involvement because it will shape the way in which we interpret the interview data" (Hollway and Jefferson, 2000, p. 30).

In line with the FANI method, semi-structured interviews were used to gather data from HVs; this involved preparing a series of open ended questions in relation to the research topic. The questions intended to allow participants to freely explore their experiences and gain rich, descriptive data through narratives. The participants were presented with the same questions in the same order to provide reliable and comparable data. However, it was also considered that the flexibility of the interview process may lessen reliability. Questions posed to participants were used as a *guide* to focus participants' responses and the open style of interviewing allowed HVs to reflect and make emotional associations in relation to their work with IMH. The FANI method requires a second interview take place a week after the first. This allowed for contradictions, inconsistencies, avoidances and changes in emotional tone to be considered.

2.1.1   Setting and research participants

The setting for the research was HV practice; the sample of participants came from a cross section of HVs in the county. The county where this research took place is in one of the

poorest parts of the United Kingdom but has some of the highest living costs; there is great

disparity between those who are poor and those who are comparatively wealthy. This is

demonstrated in the "high house prices, driven up by demand from relatively wealthy

retired people and second-home owners." (Wikipedia, accessed, 2020). Furthermore, there

is little ethnic variation with approximately 98% of the population being white British and

English speaking.   (Wikipedia, 2020).

The process of recruitment involved contacting HV senior managers, gaining support and

then telephoning / emailing HV locality managers. There are six HV localities in the county

and I approached three. Visits were arranged to two locality meetings to present the study

and ask for volunteers. The third locality had no meeting; however, I was able to recruit a

HV in this area through word of mouth. In total five HVs were recruited, one HV had

recently changed jobs (in the last three months) but was recruited as she had recent

experience.

Ethical Considerations

When IMH concerns are discussed it can evoke strong emotional responses. This was

considered ethically and I provided each HV with details of the local counselling service for

Trust staff.   Furthermore, safeguarding is often associated with IMH concerns and these

issues were dealt with by HV teams in the usual way. Hollway and Jefferson (2000) also

suggest the participant may need to debrief negative aspects of the interview. However, I

discovered that the HVs I interviewed told me they did not want to debrief but instead

needed assurances their information would not be identifiable. When the HVs agreed to

participate they received an information consent form telling them how their information

would be used. However, I needed to go further and provide verbal reassurances to nearly all the HVs, that their information would not only be anonymised, but also the Trust in which the research was taking place, would not be identified in the thesis or any later publications.

Inclusion /exclusion criteria

This study purposefully focused on HVs because I wished to extract clear and consistent data based on HV knowledge and experience. They did not need be experts in IMH but it was helpful to include HVs who had attended the Solihull Approach training and some who had not. I briefly considered interviewing HV managers; however, due to HVs concern about confidentiality I decided against this. The following table provides basic information about the HVs who participated in the study:

Table 1: Health Visitor Information

Health Visitor Locality	Universal/ Universal Plus Team	Years Qualified	Years HV in Trust	Solihull Approach Training	Previous Employment	Future Plans
HV1– Mid	Universal	1	1	No	Nurse	Changed profession
HV2– Mid	Universal Plus	7+	7	Yes	Paediatric Nurse	No plans to move on
HV3– Mid	Universal	8+	-1	No	Paediatric Nurse	No plans to move on
HV4- West	Universal	10+	10+	Yes	Women's Refuge	No plans to move on
HV5- East	Universal plus	5	5+	Yes	A&E nurse	Moving out of county

All HVs were female with varying degrees of pre and post qualification experience and job role. Data across three localities captured a cross section of socioeconomic groups.

2.2   Data Collection

Interview Schedule

The method of gathering data was face-to-face semi-structured interviews at suitable venues near to the participants' place of work such as, family hubs, council offices and CAMHS clinics. It was not necessary to offer telephone interviews as all the participants were able to meet in person. The interviews took place between November and December 2018; they were recorded and transcribed within 48 hours. In preparation for the interviews I designed eight questions; the aim of the questions was to obtain reflective responses to help participants focus on the emotional part of their practice.

1. This project is about how health visitors understand the mental health needs of children aged from birth to five. Could you give an example of the things that would make you think an infant or young child might have a psychological problem? (a) Can you tell me what kind of things in your role as Health Visitor would make you begin to think about the mental health needs of small children and infants? (b) Can you give me examples of when you have observed parent-child interactions that have led you to feel concerned or that you have needed to find out more? (c) What would tell you if things were getting better or worse?

2. How do you go about exploring the mental health needs of children-under-five, as a Health Visitor what would you do to find out more?

3. When you have had concerns about parent-child interactions or about Infant Mental Health what happens next?

4. What might you try as a Health Visitor to improve the child's/ infant's mental health?

5. What is it like when working with families when young children have psychological or mental health difficulties? (a)What feelings does this bring up for you?

(b) Can you tell me about an experience that has particularly stayed with you?

6. Please tell me if you seek support in these cases, if so who from?

7. Has anything else come to mind while we have been talking that is part of your experience of Infant Mental Health?

8. Do you have ideas about what could help to get Infant Mental Health needs addressed?

The questions began with general thoughts around IMH and how HVs explore concerns. Halfway through the emphasis of the questions changed and HVs were asked about the feelings elicited in their practice and if they accessed support.

Before the interviews, the schedule was tested with a colleague; during this I became aware of my position as researcher and the need to resist interrupting or interpreting. I realised in order to access clear and objective data, preconceptions needed to be set aside. Furthermore, to avoid yes/no answers, it was clear my task was to encourage participants to create a narrative around their experience.

Second Interview

Adhering to the FANI method, a second interview was conducted a week later. This provided opportunity to reflect on emotional responses, discrepancies, contradictions, avoidances and concerns. The second set of questions was designed specifically for each participant to find evidence to support hunches based on HV responses to the original interview schedule (see appendix). I wanted to understand more about the support HVs receive and how this seemed to only arrive as safeguarding supervision. Furthermore, why it was difficult for HVs to provide coherent narratives about families and to know more about their experiences of managing stress when there were IMH concerns. Four participants undertook the second interview; unfortunately I was unable to arrange a second interview with one of the HVs. Again the interviews were transcribed within 48 hours and nine interviews were conducted in total.
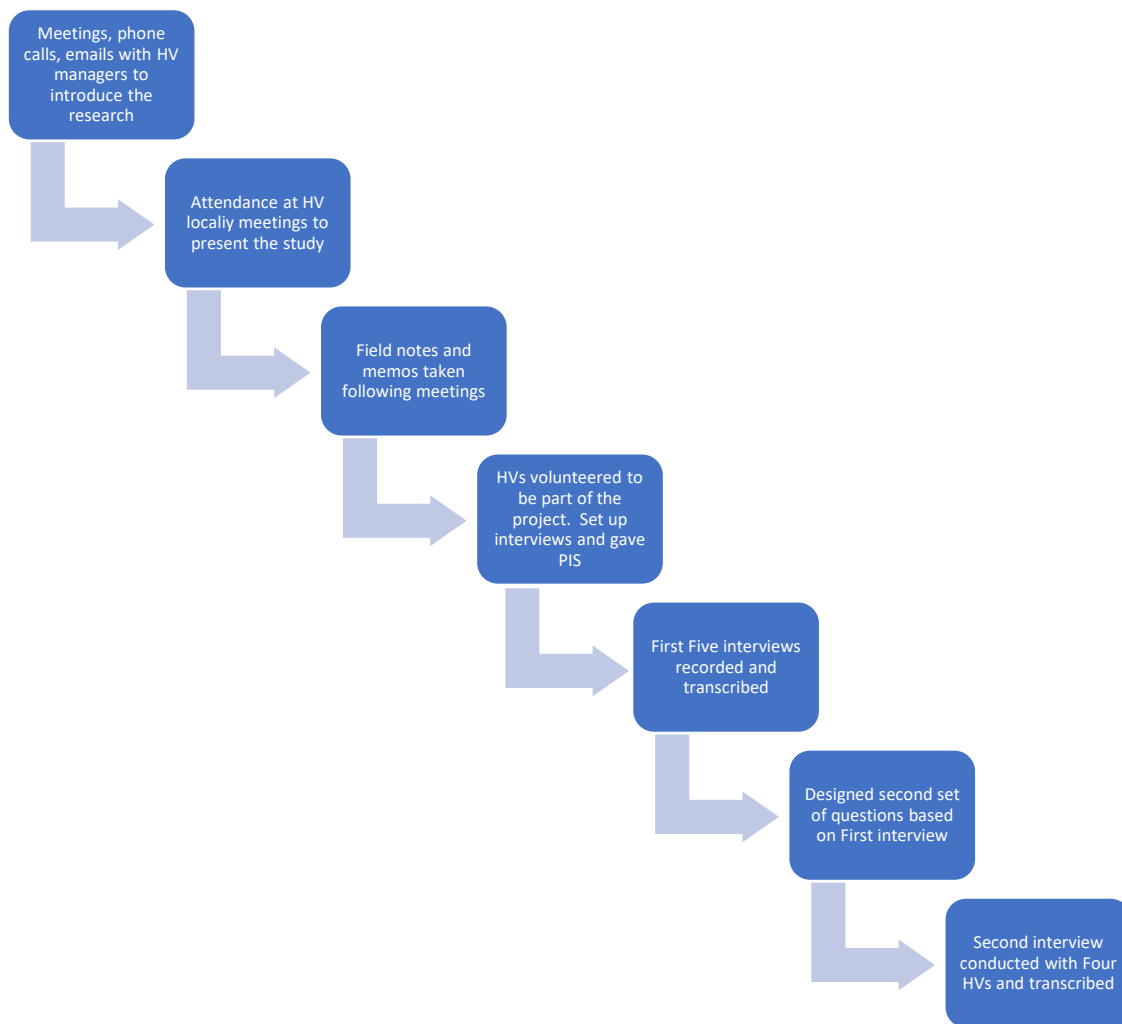
Figure 2: Flow chart Illustrating Methods Used to Gather Data

2.3   Method to Analyse the Data

The FANI method produced rich and thick data, however, when it came to analysing I was

dissatisfied with the method proposed by the approach. The FANI method suggested

creating profiles of HVs personal details but participants had already made clear they

wanted their confidentiality protected. Furthermore, FANI did not give the rigor and level of

strategic analysis I wanted to apply to the data. I discovered I needed an alternative

method to distance myself and break into what lay beneath. This required a qualitative

method of analysis which managed researcher bias and provided rigour to meet

generalizable research standards to provide reliability. The method also needed to be flexible to fit theoretically with how the data had already been collected using the FANI approach. These issues led me to thematic analysis which is suited to the broad and exploratory question of this research. Thematic analysis is "essentially independent of theory and epistemology, and can be applied *across* a range of theoretical and epistemological approaches." (Braun and Clarke, 2006, p. 5).

2.3.1 Thematic Analysis

Thematic analysis is a phenomenological approach to research and concerns understanding how another person makes sense of the world. The method is implicitly framed as essentialist or realist (Aronson, 1994) and seeks to report experiences and meaning to reflect the reality of participants and "unravel the surface of 'reality'." (Braun and Clarke, 2006, p. 9). This involves the researcher focusing on observable or semantic content (in the context of this research this involved focusing on the transcripts from the semi-structured interviews) and then analysing what lies beneath, (Boyatzis, 1998) to find a rich and detailed complex account of the data.

The process of thematic analysis consists of the search for themes which emerge from the data to describe the phenomenon. According to Fereday and Muir-Cochrane (2006), "It is a form of pattern recognition with the data, where emerging themes become the categories for analysis." (2006 p.82). Themes are where the interpretative analysis of the data occurs (Boyatzis, 1998) and identified themes demonstrate something significant, promote understanding, help construct a story and illuminate the research question.

Within thematic analysis there can be two approaches, deductive and inductive, the approach used in this research was inductive. This means the themes identified are strongly linked to the data (Patton, 1990) and may bear little relationship to the questions participants were asked or any relation to the researchers theoretical interest (Braun and Clarke, 2006). Also, the data was analysed *across* the data set providing an overall detailed analysis of the HV interviews.

In thematic analysis, Braun and Clarke (2006) highlight how themes do not reside in the data but in the mind of the researcher "from our thinking about the data and creating links as we understand them." (Braun and Clarke, 2006, p. 7). The researcher needs to recognise their use of judgement to determine the theme and this requires a need to understand the researchers personal context (Boyatzis) and the context of the research. As described in the introduction the context of this research is set within the field of psychoanalysis and child development research. Therefore, in line with an inductive approach, this research attempted not to overtly influence the data. This was attempted by not engaging with the literature review until the bulk of the data analysis was completed. On its own, thematic analysis offers a description but alongside a theoretical context, analytic claims can be begin to be validated (Braun and Clarke, 2006).

According to Boyatzis (1998), thematic analysis is poorly demarcated because there is no clear agreement as to *how* to do it. However, this flexibility can also be a strength as long as a rigorous systematic method is devised (Reicher and Taylor, 2005). Using a systematic approach akin to grounded theory, I designed a way to manage the large amounts of data.

The process involved several stages, this allowed for increased self-awareness to lay aside preconceptions, develop a reflexivity and apply critical reflection.

The process of analysis requires immersion into the data, this was done through the transcribing of all the interviews verbatim. Lines of data were then coded and condensed into concise units of data, enabling data to be organised into meaningful groups and begin to move beyond the narratives in the transcript, while remaining close to the data.   Over time patterns of the observed phenomena develop and categories emerge offering insight and enhancing understanding.   Throughout analysis there is a non-linear process of constantly moving back and forth between the entire data set and rereading the data to continually develop and refine. This approach of thematic analysis distances the researcher from the data and allows for study replication, this provides rigour to meet generalisable research standards.

As part of the method, field notes and memos were written throughout the duration of the project. The notes provide an audit trail and in the final stages of data analysis memos were grouped, sorted and compared. This adds an extra element to the data set and helps realise any gaps.

2.4   Data Analysis – Thematic Analysis

Table 2: Stages of Thematic Analysis

Stages	Analysis of data

1	Random Line by line coding
2	Selective Line by line coding
3	In-vivo coding
4	Initial sorting for themes
5	Initial categories
6	Emerging categories (using in-vivo codes)
7	Secondary sorting for themes
8	Clustering around themes
9	Return to original transcripts and field notes
10	Focused selective coding
11	Analysis of interrelating themes

Random Line-by-line coding

Initial data analysis began with line-by-line coding. One page from either the first or second interview was chosen at random. Each line on the page was numbered, separating the data into distinct segments, the action or meaning in the line was summarised and named to define what was happening or being experienced. This enabled data to be broken down, "moving beyond the concrete statements" (Charmaz, 2006, p. 43). The following table provides an example of how the text became condensed to find the truth at the heart of the text:

Table 3: Examples of random line-by-line coding

HV	Line	Text from interview	code

HV	Line	Text from interview	Code
HV1a	6	*She's getting the right support through our services, it might mean that baby is more settled*	Getting the right support aids infant mental health
HV2b	1	*Those ones where you feel like concerns are escalating, lots of your cases might be escalating*	Escalating concerns
HV3b	27	*To actually get through the door, you know we've made it, we've kept the appointment*	Getting through the door is an achievement
HV5b	1	*I think she's low and she's got a mental health diagnosis historically*	Recognising maternal mental health difficulties

Selective line-by-line coding

For selective coding, one page was chosen from the first or second interview, if the transcript already had a page randomly coded I chose the interview that had not been coded. This allowed all the interviews, to have one page coded either randomly or selectively. In the selective process, pages that contained full and rich narratives were chosen to potentially provide codes that described a less defended position of the participant. The following table provides examples of the selected codes:

Table 4: Examples of selective line-by-line coding

HV2a	30	*He said "you know that's the first time I've felt anyone's actually spoken to me"*	Father feeling validated
HV3a	16	*And end up having to speak to your family about how stressful work is*	Taking stress home
HV4b	33	*Poor childhood experiences herself, she is in a mother and baby unit about to close*	Mother experiencing deprivation
HV5a	12	*In and out of crisis, one day we'd made a really good working relationship*	Making relationships during crisis

In-Vivo Codes

During the random and selected coding process there were several lines that stood out and did not need to be coded because they were already powerful statements. These are called in-vivo codes and are direct quotes from the data. These codes captured or summed up something significant and 'live' about HVs' experiences. The table below shows some of the in-vivo codes found in the line-by-line coding:

Table 5: Examples of Initial in-vivo codes

HV	Line	Text from interview – In-vivo code
HV1a	21	*"I don't have friends over because my toys are all dirty"*
HV2a	3	*What is my role?*
HV3a	20	*Further undermines our role which is already really shady and shaky*
HV4b HV4a	23 22	*It's the little things you're doing, those little things with huge knowledge* *She wasn't in my remit*
HV5a	7 33	*Complex mental health diagnosis with small children and I was like whoa I feel out of my depth* *I couldn't hold her*

Initial sorting for themes

The next part of the coding process concerned identifying initial themes. The coding generated huge amounts of data and to try to access and familiarise myself with this wealth of material, I re-read through the codes. When I noticed similarities that could be named, this generated a theme which allowed some codes to be grouped together. Through this process of familiarisation eight themes were identified:

1. Need and concerns
2. HVs' experiences
3. Role / responsibilities
4. Under pressure
5. Misunderstood
6. Broken system
7. Family
8. Comparisons

The sorting process to find a theme was thoughtful and long, codes were compared and contrasted and separated into groups (see appendix D: Initial Mapping of Themes). If they appeared to share similar meanings they were grouped together, if not the process would begin again until a suitable fit was found. Sometimes codes clearly belonged to a theme, some needed to be entered into more than one theme and sometimes the theme did not seem to adequately reflect the code at all. This process allowed the large amount of data to be sorted and for familiarisation with the data. The table below provides examples of how codes fitted into themes:

Table 6: Examples of Codes Fitting into Themes

Initial Themes	HV	Line	Example codes
Needs and Concerns	HV3a	39	*Worried about cases that don't meet threshold*
	HV3a	40	*Some families are more risky than they seem*
	HV5b	2	*Mother vulnerable and exhausted*
HVs' Experiences	HV2b	22	*Feeling stuck*
	HV3a	32	*Explaining intense feelings*
	HV3b	31	*Observing children's difficulties*
	HV5a	7	*No idea about mental health until dealing with it*
Role/ Responsibilities	HV1a	2	*Measuring concern*
	HV2a	7	*covering key messages*
	HV3a	6	*Maintaining relationships with families*
	HV4b	25	*Little ordinary things like weighing*
	HV4b	28	*Finding an inward road*
Under Pressure	HV1a	12	*Little time to reflect*
	HV3b	26	*Not enough time with families to prevent problems*
	HV5b	10	*Additional pressure when parents need help*
Misunderstood	HV2b	17	*Focusing only on medical needs*
	HV3b	20	*Feeling undermined "shady and shaky"*
Broken System	HV1b	11	*Long term neglect and child protection*
	HV2a	36	*Feeling things won't improve*
	HV2b	5	*Sickness in the team*
Family	HV4b	19	*Parents struggle to come back for help*
	HV4b	35	*Mother is supported by her partner*
Comparisons	HV3b	19	*Identifying with mothers*

Initial Categories

Prematurely, I put themes into categories in relation to the volume of codes and tried to categorised themes on this basis. For example, 'health visitors' experiences, 'role and responsibility' and 'needs and concerns'. This created the following matrix:
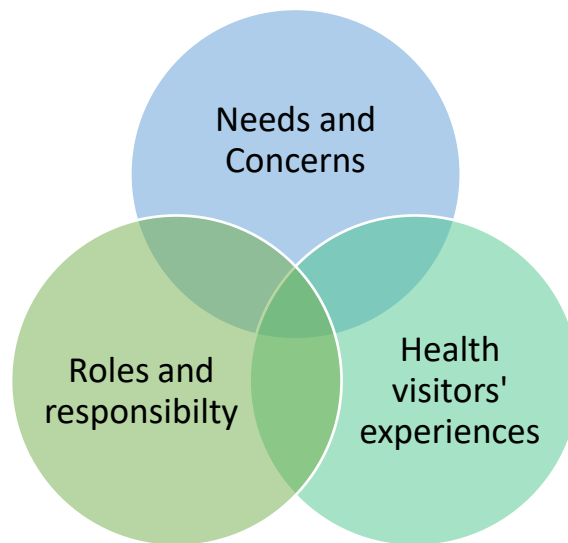
Figure 3: Matrix of Initial Categories

These somewhat premature categories were thin, lacking in adequate description and were not conceptualised. In fact some themes, although holding large amounts of codes, did not form a category. In particular, 'Health visitors' experiences' and 'roles and responsibility' did not reflect or describe the codes in depth. This reflected how I did not really understand how to group these codes. Although, this foray into categories was too generalised it provided a learning experience and confirmation I needed to return to the data. This process of moving backwards and forwards formed the way in which categories and themes were generated and developed.

Emerging Categories (Using in-vivo codes)

I returned to the in-vivo codes because these dynamically reflected something of the HVs'
experiences, such as 'shady and shaky', 'what's my role' and 'investing work into a family.'
To delineate between particular codes, I created clusters of codes around pertinent in-vivo
codes, this refocusing allowed clearer categories to emerge, see table below:

Table 7: Examples of Emerging Categories

In-vivo code	Description of Grouping	Describing Words	Category Labels
'Investing work into a family'	Hanging on to something get on with the task	Tie-Down Bedrock Loadstone	**Anchored**
'Shady and shaky'	Blocked system Deprivation	System blockage Strained processes	**'Shady and shaky'**
'What's my role?'	Being on the brink of understanding/ a relationship Confusion Uncertainty Doubt	access, gateway opening admittance connect keyway	**'Threshold'**

Also at this stage I used a thesaurus and google synonym searches to revise words or
phrases that could describe themes and categories. The new distinct labels provided a
starting point but there were still codes that needed more exploration. These codes
described practical tasks and experiences about rejection, isolation and battles.

Secondary Sorting for Themes

This initiated a fresh round of comparing, contrasting and sorting, codes were placed into
three categories, 'anchored', 'threshold' and 'shady and shaky'. Throughout this process I

referred back to the 'initial sorting for themes'. All the codes were photocopied on to strips of paper and placed under the category that best described them (see appendix E: Sorting for Categories). This method allowed for codes to be moved around until a fit was found. Only a few codes were duplicated under more than one category.

Once codes began to build, clear themes emerged and these were grouped and clustered around a category. I then listed the properties of each category, this helped clarify and draw out identifiable themes. However, in the 'threshold' category, although several codes fitted it was difficult to group them into themes. Therefore, I returned to the original, transcripts, memos and field notes to gain greater insight, not only in this category but for all the categories.

Second round of data analysis - Return to Original Transcripts and Field notes

The purpose of returning to the original data was to look for themes not already highlighted in the categories and also to confirm and substantiate the existing categories/themes. I collected new focused codes and assigned them to existing categories. This process enhanced my understanding and generated more definite themes.
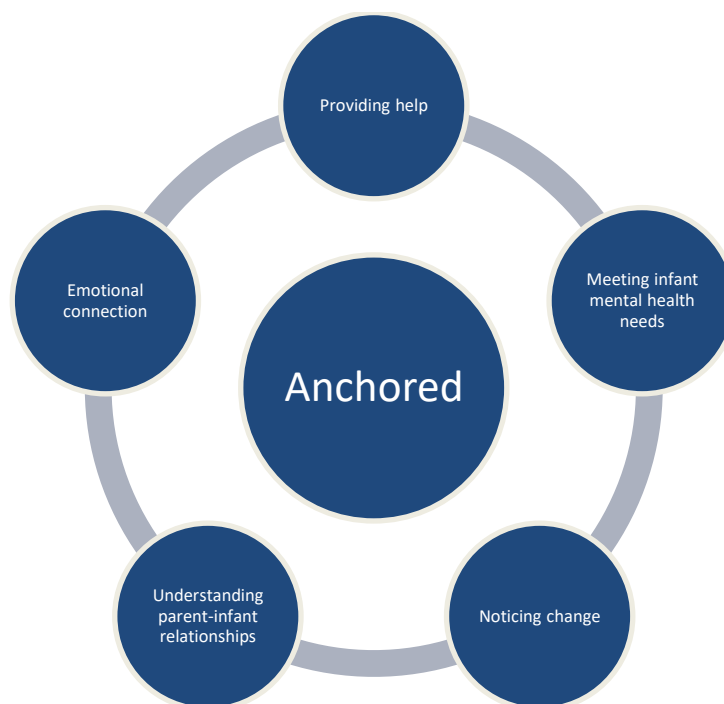
2.5 Anchored

The category of 'anchored' was already established before the second round of data analysis but the process of adding focused codes enabled clearer distinctions between themes, see table below:

Table 8: Development of 'Anchored' Themes

Category	Themes	Focused Selected Codes	Random / Selected Codes
Anchored	Providing help	*We have to have difficult conversations*	*Strong position to support*
	Meeting mental health needs	*Noticing having a baby is a stressful event*	*Improving maternal mental health*
	Observing change	*Families becoming less defensive*	*Exploring development over time*
	Noticing positives	*Dad was a protective factor*	*Mother is supported by her partner*
	Emotional Contact	*Consistently working with a family*	*Accepting hopelessness*

These themes cluster around the category of 'anchored', the figure below shows how these themes interrelate with the core category:

Figure 4: **Clustering of Themes around 'Anchored' Category**

2.6 'Shady and Shaky' – Adrift

This category was already distinct and defined before the second stage of data analysis but the new data led to an overall greater understanding. 'Shady and shaky' had helped to begin conceptualisation but these words were too vague and evocative. Therefore, the category was renamed 'adrift'. The table below illustrates how themes were enhanced by the second round of focused and selected coding:

Table 9: Development of 'Adrift' themes

Category	Themes	Focused selected codes	Random/selected codes
Adrift	Excluded	*I can't get into that home*	HV felt sacked
	Shady and shaky	*I was doubting my own judgement*	Mother vulnerable and exhausted
	Overwhelming anxiety	*Noticing everyone is overwhelmed*	I feel out of my depth
	No capacity	*Contact visits cancelled*	Not spending enough time with families
	Unsupported	*No reflective supervision set up*	Feeling alone with a risky family
	Broken system	*Waiting for it all to go pear shaped*	Giving up on a child

The themes linking to 'adrift' relate to each other and also relate to the category as a whole.

The diagram below illustrates how the themes cluster around 'adrift'.
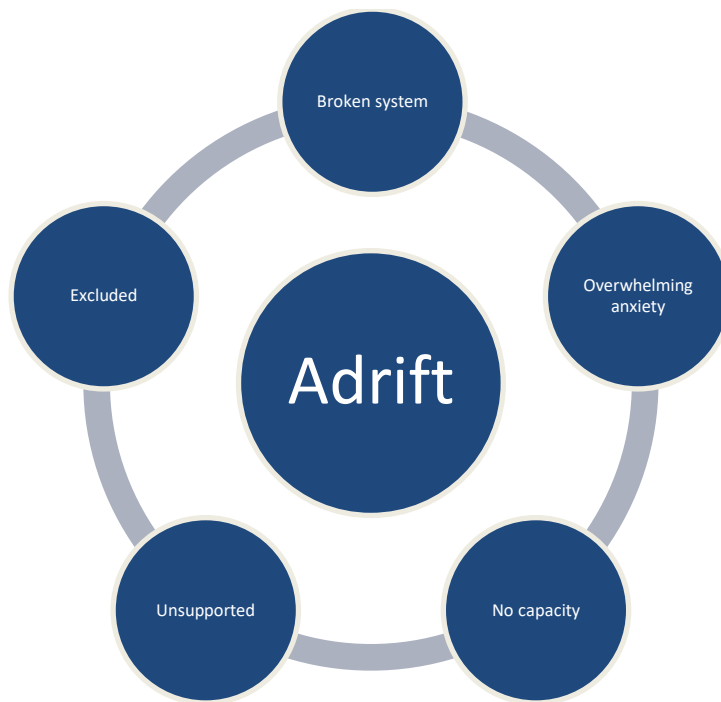
Figure 5: Clustering of Themes Around 'Adrift' Category

2.7   Threshold – At the edge

This category posed a problem, it was difficult to name themes from the codes initially generated. As a result of secondary analysis the title of the category changed because the new themes dictated a name that described not only the concept of a threshold but also that which encompasses something of its emotive aspects. Therefore the category was renamed, 'at the edge,' (see table below).

Table 10: Development of 'At the edge' themes

Category	Themes	Focused selected codes	Initial Random/selected codes
	Loss and change	*I hold on when I shouldn't*	*Moved to the plus team*

At the edge	Crossing a barrier	*Overstepping that professional boundary*	*Needing to find an inward road*
	Battling	*Fighting a battle*	*Walking away when the HV arrives*
	Limitations	*I knew I was at breaking point*	*Worried about cases that don't meet threshold*
	Confusion	*They all sort of merge*	*What's my role?*

In line with the other two categories themes cluster around the 'at the edge', the figure below shows how these themes interrelate with each other and the core category:
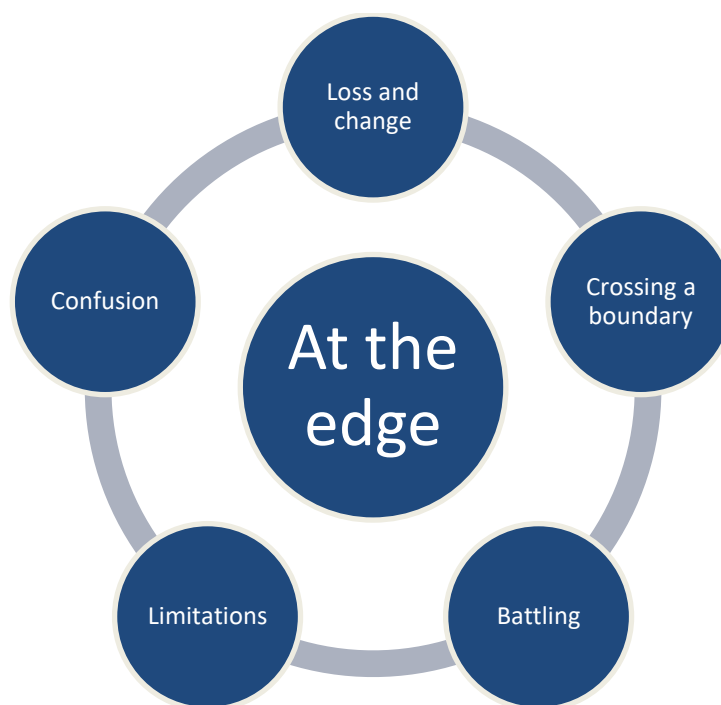

Figure 6: Clustering of Themes around 'At the Edge' Category

This chapter has provided a clear overview of the method and how the analysis was undertaken. The next chapter will present the findings.

3   Findings

The following chapter presents a description of data gathered from five HVs. Ten pages of transcripts were coded, producing approximately 360 codes. Additional codes were added following further reading of the transcripts and memos. Thematic analysis generated three main categories for HVs' experiences of IMH concerns: 'anchored', 'at the edge' and 'adrift'. Each category contains five themes; these will be described using codes and quotes from transcripts. The diagram below provides an overview of the categories and themes:
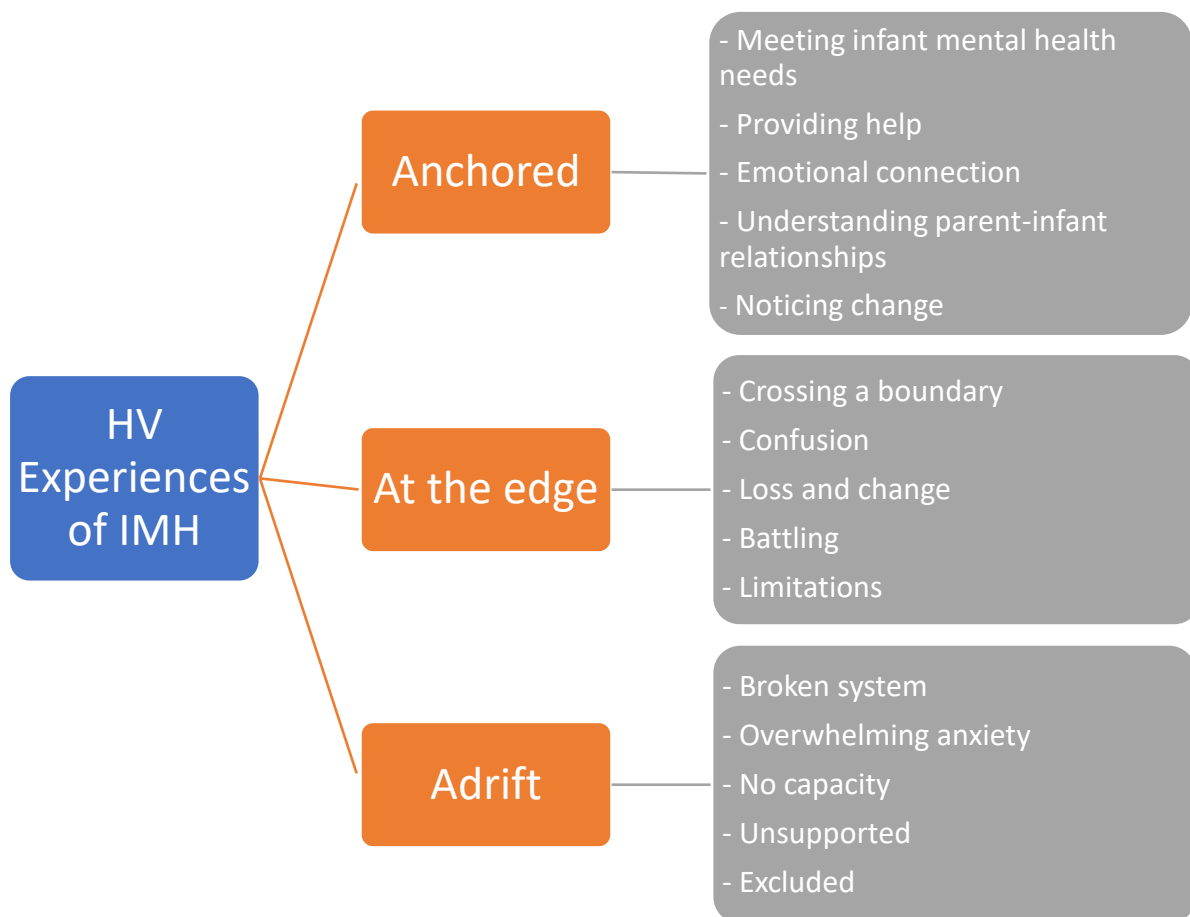
Figure 7: Overview of Categories and Themes

3.1   Anchored

'Anchored' encapsulates codes relating to core HV skills and illustrates HVs' experiences of being able to use their skills to deliver 'good enough' services. Codes in 'anchored' relate to role clarity and how HVs use their knowledge and expertise to fulfil their role. Families in this category want to engage with their HV and several codes described how HVs universal role allows them to discuss the emotional pressures of having a baby with parents.

In 'anchored,' HVs accept managing uncertainty, change and risk as part of their role. HVs also gave descriptions of relationships which extended to colleagues, management, legal frameworks and partner agencies. These relationships demonstrate the reciprocal equilibrium between HVs providing support and receiving it. When codes were grouped together, five distinct themes emerged to provide greater clarity. These themes will now be described:

Meeting infant mental health needs

This theme refers to how HVs describe experiences of attending practically to and thinking about, '*meeting infant mental health needs,*' demonstrated in the following codes:

> *'Leading with a depth of knowledge' HV2b.*
>
> *'Having knowledge gives support'HV4b.*
>
> *'Visits focus on the child' HV5a.*
>
> *'A need to question curiosities' HV5b.*

The codes demonstrate HVs using core skills to identify problems early and assess/measure the general physical and mental health of parents and baby. During these checks HVs cover, not only key health messages but in the process are given a 'way-in' or as one HV described:

'We're the bait' HV2b.

Another way-in and core to HV practice is beautifully explained in the following quote:

'Loads of people think HVs weigh babies, oh if only, (laughs) how much I can see in a clinic contact; in a ten minute spot of somebody just weighing a baby. There's a lot I can tell you,' HV2a.

HV2 describes how, in the fairly ordinary task of 'weighing', she is assessing and measuring more than just weight. She is using several other skills at the same time but suggests that in the mind of parents' she is *'just weighing.'*

HVs also discussed developmental reviews which assist them in considering whether IMH is getting better or worse. HVs ask *'specific questions'* providing clarity to make sense of what the HV observes and how this relates to child development. Codes that demonstrate this are:

'Understanding children's behaviour' HV1a.
'Using a range of assessment tools to measure development' HV1a.

In the following quote HV1 describes how she evaluates and investigates her discoveries and that the review may get repeated in order to check her assessment:

'Sometimes that can pick up on different elements and sometimes you're using scoring…sometimes you'd go back and review,' HV1a.

Providing help

This theme describes how the scope of the HVs role enables them to read and deal with stressful situations, understand child/ infant behaviour and give advice:

'Pick up where others have left off' HV3a.

'HVs are in a 'strong position to support families' HV4a.

'Knowing birth is a stressful event' HV3b.

'Help with routines and boundaries' HV1.

This theme relates to HVs skill in knowing *when* to sensitively give advice:

'Understanding not everyone needs advice' HV4b.

'It's the little things that you're doing, those little things with huge knowledge. So you're praising a mum for being a good parent … but you're doing that with knowledge, you're knowing when to praise, how to praise' HV4b.

HV4 suggests her experience and knowledge of working with parents and IMH concerns is communicated through simple interactions. She explains that the value of her work is

difficult to capture, perhaps appearing simplistic, 'it's the little things'. In reality, however, there is complex thinking alongside a simple interaction. This was echoed by other HVs who talked about instinctive responses:

> *'Having niggling feelings'* HV1a.

These hunches, not easily explained, suggest that key to the application of HVs *'providing help'* is experience/knowledge and by keeping advice simple and well timed, barriers to difficulties can be broken down.

Codes in this theme describe how HVs manage the limitations or scope of their role, for example in the code:

> *'We can only be responsible for what we see'* HV2b.

This code came from a HV explaining a very complex and uncertain situation. Her initial assessment of the parent-infant relationship, despite a few concerns was good. However, following this the baby needed to be hospitalised with unexplained injuries:

> *'We don't know how he did it, there's no account for it and again you start to think… But I can rationalise that… I can only be responsible for what I see at the time and that's what I saw at the time. Even now they've had all safeguarding medicals they don't think that it's non-accidental but it's just one of those we don't know,'* HV2b.

HV2 explains her struggle with the limitations of her capacity, she cannot see everything. The outcome is worrying and will require close monitoring but HV2 is able to rationalise '*she is not responsible*.' HV2 concludes she fulfilled the scope of her role, doing what she is trained to do. Arguably, HV2 may be defending against anxieties around feeling responsible. However, her acceptance, that she doesn't have all the answers, seems effective for her to function and still feel she can '*provide help'.* This demonstrates how the role of HVs can be uncertain and at times feeling overwhelming but possible.

Also linked to this example is 'knowing' when to end work, signpost to other services/agencies or when to utilise shared frameworks between agencies, such as safeguarding. The process of and knowing *when* to ask for help, through enlisting other agencies or seeking advice through supervision is demonstrated in the following code:

'*Any professional supervision is helpful*' HV5b.

This help allows HVs to feel supported in difficult, uncertain circumstances. Furthermore, analysis of other codes demonstrates an essential awareness that although families receive help, it may not be perfect, captured in the following code:

'*There is a support plan but it is not perfect*' HV4b.

The codes in '*providing help*' identify how HVs support families but how they also receive support:

'Just knowing there is somewhere to go, there is someone to ask, can be enough.'

HV4b

This demonstrates the importance of an integrated support system, not only around the family but for HVs and other agencies. Even if the system is imperfect, it provides some means of managing uncertainty and distress.

Emotional Connection

The theme '*emotional connection'* attracted the most codes during analysis, it describes the importance of HV relationships with families illustrated by the following codes:

'The relationship is important' HV4a.

'The only person consistently working with families' HV2b.

'Knowing a family's difficult past' HV2a.

'Children evoke emotion' HV1a.

These codes also detail how HVs invest in relationships:

'Get alongside families trauma' HV2b.

'Having difficult conversations' HV3a.

'Looking at both sides' HV1a.

'Remain resilient' HV3a.

HVs explained how they put themselves '*in the shoes*' of mothers, fathers and babies, using their own experiences to reflect and understand feelings. HV5 explained this as having:

'Better understanding of what it is like to live in their shoes' HV5a.

Also related is how HVs identified with children based on their own childhood experience or with parents founded upon their own experience of motherhood. One HV describes how motherhood changed her view:

'I could detach myself quite easily when I was younger. Then I had my own baby …my practice isn't different, the knowledge is exactly the same but I think it brings out something else…and I do...You do worry,' HV3a.

HV3 identifies how before motherhood, she could 'detach' but becoming a mother heightened her awareness. In this state, HV3 integrates her own life and work experiences to make better emotional connections. Several codes demonstrated how HVs picked up on parental emotions by identifying with the family. In the following quote, HV3 in her second interview describes the resilience needed to empathise with what seems like, a depressed mother:

'It sort of has a mirroring effect, so you're sat with somebody who isn't very animated, you know is really struggling, aspects of their life are really difficult and really turbulent,' HV3b.

HV3 discovered a way to understand this mother but found herself adopting similar body language, as if she is taking in some of the distress and 'mirroring' this back to show she understands:

> *'Then you almost sort of mimic that sort of body language that sort of non-verbal's and it's difficult then to sort of find yourself again,' HV3b.*

HV3 is aware of the emotional impact this has upon her, she explained this as, losing herself and accepts this as the emotional cost of empathy:

> *'Then when you come out of that visit you've got to sort of sit in the car, take a big breath and sort of try and move on,' HV3b.*

HV3 explains how she is resilient and able to find herself again. Several other codes from HVs described similar empathic processes with families that explained the necessity of really understanding and getting alongside families' trauma. These empathic emotional connections include, positive emotional responses, feeling relief when things get better and more challenging responses, such as:

> *'Accepting hopelessness' HV3a.*
>
> 'Concern about power differences' HV5b.

In terms of power differences, HVs can represent an external authority figure for parents, particularly in relation to safeguarding responsibilities. Furthermore, HVs observe the

power difference between children and parents, noticing children's vulnerabilities and helplessness in relation to not being cared for adequately.

Being cared for concerns a desire for emotional connection, felt not only by families but also by HVs. HVs want their emotional responses in relation to their work understood and this happens through meaningful relationships with colleagues, managers and outside agencies. Demonstrated in the following code:

'*Having time to reflect with a manager*' HV3a.

This code came from the following statement:

'*…making sure everything's happening and they're reaching their milestones but we also need that little bit of time to also sit down and reflect on our caseload,*' HV3a.

HV3 talks about meeting the needs of the child but expresses her own need to reflect on her caseload. She wants to think with someone about her work and clearly defines this need with regards to her practice.

Understanding Parent-Infant Relationships

This theme concerns HVs' experiences of using observational skills and monitoring their emotional response, to understand the quality of the parent-infant relationship and direct HVs to what families' need. This theme wrestles with the realities of having a baby and how

notions of perfection can impede parent-infant relationships. This was reflected in codes relating to mothers' *'huge expectations'* of how things should be:

'Setting the bar too high' HV5a.

HV3 exemplifies this with the following quote:

'People look at childhood, toddlerhood and new babyhood with sort of rose tinted spectacles and then you have a baby and it is blooming hard,' HV3a.

This perfection extends to understanding superficial expressions of happiness, such as an *overly* happy mother or a baby *only* smiling, demonstrated in the following code:

'Babies only showing one emotion' HV3a.

This code came from the last sentence in the following quote:

'He was incredibly sort of smiley … he was trying to seek some sort of acceptance from her… whereas … her sort of facial expressions, were very flat. He was left on the floor with his own toys things … I thought oh gosh it's lovely to see a sort of happy smiley baby but actually that's not it … He wasn't really showing any other emotion …he was trying to gain some sort of reciprocal interaction from his mother,' HV3a.

HV3 not only observes this parent-baby dyad but uses her knowledge/experience of 'good enough' parenting and attachment, alongside her emotional response to help her understand what she cannot see. On the surface the baby appears happy but the HV knows

there is a mismatch with the mother's flat facial expression. Somehow this baby has learned to smile, probably as a defence, to get responses from the mother by attempting to enliven her.

Other codes in this sub-theme captured HVs noticing child-centred interactions:

>*'Parents talking to their babies'* HV2a.
>
>*'Fathers are supportive'* HV4.

These important understandings of observations serve to support HVs, allowing assessments to be based on real experiences.

Noticing change

The codes in this theme focused on HVs ability to track families' development over time. This is succinctly exemplified in the in-vivo code:

>*'Being a constant in the family's life'* HV4a.

Codes labelled *'noticing change'* concerned HVs' experiences of being part of a child's and family's development. The following quote refers to a HV's experience of a mother's change in presentation over time but also how the mother's interaction and relationship with the HV developed. Shown in the following quote:

'Then you see them at the seven to nine month review and they are like oh your smiling you're lit up you're different and then they'll go, "yeah I suppose I was struggling a bit." And oh how many times did I ask?' HV5b.

HV5 observes the mother's struggle at the start of the relationship which the mother was unable to acknowledge. Recognising a problem HV5, tried to offer support but this couldn't be accepted, so instead the HV held the mother in mind (on her caseload). In the intervening months, HV5 may not have seen the mother but the relationship continues in the background. Until finally the mother is able to say she was struggling and this confirms the HV's conviction. This development could only be realised via the consistency of having the same HV.

Other codes relate to the value of consistent relationships HVs make. HV2 describes the huge change she experienced in a relationship with a father in the following quote:

'it was like a switch went off, the social worker said to me, "I don't know what you said but they were willing for a family worker." … He was always so defensive about everything, all of a sudden he's phoning the social worker for advice,' HV2a.

This quote captures how HV2's relationship with a father was a catalyst for change, allowing the father to be less defensive and seek help. What is missing from the quote but perhaps implied by the social worker, is the huge amount of work and resilience HV2 needed to bring about change.

3.2 At the edge

The category of 'at the edge' gathered the more complex and challenging elements of health visiting, attracting codes demonstrating HVs' experiences of the weight of responsibility:

'There's a lot on our shoulders' HV3a.

Codes contained painful observations and experiences, demonstrated in the following codes:

'The saddest girls I've ever seen' HV4a.

'Wanting to leave the shouting chaos' HV2a.

Codes in this category were hard to get hold of making it difficult to separate them into themes. The struggle to identify themes was perhaps a response to the nature of the category which in part describes HVs confusion and struggle to find a way-in to families. Demonstrated in the following codes:

'What's my role?' HV2b.

'What is the reality?' HV1b.

'Needing to find an inward road' HV4b.

'Achievement to get through the door' HV3b.

Some codes elicited visual images of HVs being at the threshold of a family's home. Interestingly, HVs use the term 'threshold' for the name of the tool used to measure the vulnerability in families and prioritise need. *'At the edge'* encapsulates something evasive, an in-between space of being on the cusp of trying to begin something. Only after re-reading the transcripts and a second analysis did well-defined themes appear. These will now be described.

Crossing a boundary

Codes in this theme describe HVs' experiences of barriers and crossing into areas that feel unsafe or dangerous. Barriers pertain to those erected by families or barriers HVs experience in receiving support for themselves with colleagues and the organisation. HV sentiment about this is demonstrated in the following code:

'Opportunity to help but frustrating' HV1b.

Several codes relate to HVs' experiences of crossing over the boundary into family homes and once through the door, struggle to find a true understanding of the parent-infant relationship. Demonstrated in the following codes:

'Tell you what you want to hear' HV2a.

'Pretending they are supportive' HV4b.

'Just go along with things' HV2a.

This denial of problems and pseudo compliant relationships is exemplified in the following quote from HV5:

> *'Dad … would welcome me to the house but declined every referral and every support offer that I made...He probably felt he had to let me in, yeah so he was just being polite. And a lot of parents will be polite, they let you in and they just, "yeah yeah," and they just give you the verbal dialogue they think they need,' HV5a.*

This interaction between father and HV5 exposes her to an experience that does not match with the difficult reality she observes and the help offered. This 'fobbing-off' potentially impacts on her sense of feeling effective and being on task in her role.

Other codes relate to professional boundaries, dilemmas and grey areas, for example when to keep hold of families or when to take a step back. This is illustrated with the following self-critical code:

> *'I wrapped them up and I shouldn't have done' HV4b.*

The same HV then goes on to provide more meaning in the following quote:

> *'You want to do it well and if you go the extra mile you might not be protected…Health visiting to me has always been trying to bend it a little to make sure you're getting what the families need … Managerial or nursing-wise it's a blame culture so if something goes wrong,' HV4b.*

In this explanation HV4 implies going the extra mile (or crossing a boundary) feels unsafe, even dangerous if this is not supported by the organisation. There were also descriptions of HVs needing to cross a barrier within themselves regarding feeling uneasy about crossing into the realm of mental health:

'(We're) *public health specialists…not mental health specialists'* HV3a.

Then once the barriers are crossed, it can feel overwhelming and unmanageable, coded as:

'Everything came through all at once' HV3a.

In 'anchored' the theme of *'emotional connection'* gathered codes about how HVs can identify with the parents and children they work with. However, in 'at the edge' this identification seems to cross a barrier. One HV described how her practice crossed over into her own traumatic childhood memories. In other examples HVs described how families *'play on the mind'* often resulting in HVs taking them home in their mind. HV2 describes this thus:

'It can be very emotive and these are the families that will play on your mind they're the ones you take home (laughs), in your head' HV2a.

HV2 suggests her sense of danger in the weakening of the boundary between work and home in her mind.

HVs also had experiences of procedural boundaries being crossed, for example, the Trust allowing band 4 practitioners to carry out six week checks. These once clear professional boundaries regarding HV role now blurred were seen by HVs as a devaluation of their skills and unsafe practice by the Trust.

Confusion

Confusion or merging developed as a clear theme, relating to HVs' experiences of uncertainty and lack of confidence regarding their role. Demonstrated in codes, such as:

> 'Being critical or not critical enough' HV1a.
>
> 'Is what I am doing meaningful?' HV2a.

HV2 describes this as not really knowing what she is doing:

> 'We all have those times those periods where we just think; I don't really know what I'm doing… I just turning up, ticking the box yeah. I'm here yes, they've been seen by a HV but what am I actually doing?' HV2a.

HV2 describes how her sense of meaning can be impacted upon by meaningless exercises, making her question the value of her role.

The theme of confusion extends into HV experiences' of feeling confused about IMH. Many HVs felt they lacked knowledge, feeling they get things wrong or become confused with what parents say:

'You can get so lost in parents sometimes' HV1a.

'Misunderstanding at first glance' HV1a.

'Having to take their word for it' HV1a.

HV2 describes how difficult and uncomfortable this risk can be to manage:

'The hardest part was not knowing how to be with the parents, after all these concerns and allegations had been made… (She was) still not admitting …that was the difficulty... Before that I'd been their source of support but it's...it's really really difficult, I didn't quite know how to handle it,' HV2b.

HV2 explains how she had been the parents, 'source of support' but that this relationship had been impacted upon by the parents' denial around safeguarding concerns. HV2 finds this 'really difficult', not knowing how to respond or keep a sense of reality. She has become disorientated and confused, suggestive of a frightening, unchartered new territory, while simultaneously needing to maintain her relationship with the family.

Several codes related to the volume of families and information HVs need to retain in their minds. Several HVs become confused about which family was which, one HV told me:

'They all sort of a little bit merge' HV4a.

This merging seemed to develop as a result of working with many families. HV3 tangibly describes her experience of what happens when there are so many to hold in mind:

'We have to remember. There's so much information and so many families and different areas that I think it becomes a point where I just cannot retain anything else, there's no.. nothing else I can, only cope really with … that sort of weeks work and deal with whatever comes next as it happens, it's really knee jerk,' HV3a.

HV3 explains her experience of, not only remembering the needs of each family but also where they are geographically. She manages this sense of merging by responding to what is needed there and then, implying things are not thought through (knee jerk). Whether this is the case or not, this is her experience, the merging perhaps impacting on her perception of the quality of care she offers. This difficulty in processing was demonstrated in some of the incoherent narratives during the interviews, as if the confusion was being re-imagined.

Loss and change

Some codes detail how much change families go through and the impact inconsistencies have in relation to children and the impact on HVs of suddenly adapting to change and loss. Codes relating to change were:

'Came out of the blue' HV2b.

HV3 describes what it is like for her when several families all suddenly go through change and erupt, in the following quote:

'I feel quite deflated at the moment I suppose because … there's a few families that have just, I want to say, blown up… it's like a volcano sometimes everything's ticking along then all of a sudden things are happening in these families lives,' HV3b.

HV3 likens her experience of family change, to a volcano or something 'blowing up.' This creates an image of things going everywhere, no order and an imagined dangerous mess that will need managing. She does not explain why she feels deflated but it may be that these developments mean spending more time with these families and helping them adjust to change.

Other codes describe how some families are moved between HV teams depending on their risk and safeguarding issues, demonstrated in the code:

'Moved to the plus team' HV5a.

Codes also related to how HVs felt they constantly had to manage change in their practice and in the organisation:

'Constant change is not good for staff or families' HV4b.

Also changes in procedures (the scope of their practice) and moving the HV service from health to the local authority brought a sense of loss, demonstrated with the following code:

'Grieving around the changes' HV4.

Battling

Every HV referred to some sort of a battle they had to fight, this is embodied in the following in-vivo code:

'Fighting a bit of a battle a lot of the time' HV2a.

The theme of battling describes the many kinds of battles HVs experience. For example, the battles that take place within families. In these circumstances HVs must help families understand the impact of domestic violence. One code linked the parental stress of a new baby with domestic violence:

'One-off instance of domestic abuse after the birth of a baby' HV1a.

This is demonstrated in the following quote:

'I think domestic violence is the one that lots of parents say "they didn't see it, they were in bed," and you're thinking the noises or the doors are slamming, there was shouting… people … don't always realise the actual impact on those children.'

HV1a

In other circumstances HVs witness something akin to families in battle; this is described in HV2's experience of when she arrived at a family's home:

'(I) got to the door and it was just chaos, dad was shouting at the oldest child… they'd forgotten I was coming … answered the door and was like "oh" (laughs)

"health visitors here." So I was just really honest with them… he's been a really difficult dad to engage and we sort of talked about what it feels like for the children and he has been quite aggressive towards members of staff to the point where, … we were joint visiting.'

<div align="right">HV2a</div>

In this quote the HV is exposed to an uneven power ratio where the father chastises the child. She explains, she was honest but to do this she had to stand up to the father, challenge him and to get him to understand the child's position. It is only at the end she says that this man had been aggressive. In the category of 'a*t the edge'* battling is about withstanding something extremely difficult or dangerous and finding a way through.

HVs also experience battles in relation to the system in which they work, demonstrated by the following quotes:

'Justify to your manager why you have to go back and see a family' HV3b.

'Fighting for their corner' HV4a.

Part of HVs battle concerns feeling as if their profession is under attack, described in the following quote:

'From the government's perspective and from …a funding point of view …it always feels like we're battling trying to prove what we can achieve,' HV3b.

Codes in this theme concern HVs internal fight for survival to deliver effective services, this is versus an external battle to survive in the current climate.

Limitations

The limitations theme concerns HVs' experiences of reaching the limit imposed on them by capacity, the organisation and by the families they work with. This is different from the limitation that arose in 'anchored,' in the theme of 'providing help'. Limitations in this category relate to HVs recognising the limit of their role. In 'at the edge' limits pertain to risk and practice which makes HVs feel unsafe. Limits imposed on HVs by the family are coded as:

> *'Limited with the bit we see'* HV2b.

Or observing when a mother has reached her limit:

> '*Knowing when a mother cannot manage'* HV1a.

The following quote gives an example of a parent-infant relationship that has reached the limit of what can be achieved at that moment:

> *'She was obviously upset and she had to go to a refuge in the end … I did query and wonder if baby (was) just so settled because this is a really stressful and difficult situation and maybe there isn't the capacity for mum to be able to manage anything else em, that it…just it needs to be this way, this baby at this moment in time.'*
>
> HV1a

Several codes encapsulated HVs painful experiences when they reach the limitation in relation to the scope of their work and their capacity to deliver support:

'*No simple quick fix*' HV2a.

'*Between a rock and a hard place*' HV3a.

'*Wanting to do more*' HV3a.

These sentiments are expressed distinctly in the following quote:

'Sometimes we're so limited with what we can do to support; it's very much that you know is it good enough. It's really hard and sometimes those calls are the ones that stick with you. They're the ones that you go and agonise over and think maybe I need to do something else or I should get some supervision on this,' HV2a.

HV2's description of reaching the limit impacts on what she can provide, however she is still on task but the agonising feeling that accompanies this experience makes the situation risky. Limitations also relate to HVs own internal limits, and how difficult it is to put boundaries around the work, described in the following quote:

'You do … question yourself … do I need to be doing more constantly. I'm thinking, is there anything else I can do or do I need to do more?' HV2b.

Other codes relate to how HVs struggle to put limits around their capacity to look after others, sometimes this may be to the detriment of their own needs:

'Looking after others but not looking after ourselves' HV3b.

This impacts HVs internal capacity and how this can reach the limit explained in the following codes:

'Amazed not gone off sick' HV2b.

Codes also communicated how some HVs feel limited in their IMH skills:

'Feeling we don't have enough skills in IMH' HV5b.

This is exemplified in the following quote:

'No idea, it wasn't until I was dealing with it and dealing with people with significant diagnosis overlapping sort of complex mental health diagnosis with small children and I was just like, whoa, I feel out of my depth,' HV5a.

This quote gives an example of the collapse of a boundary between the complex interface of adult and child mental health.

3.3 Adrift

This final category of 'adrift' was initially hard to separate from 'at-the edge.' However, further immersion in the data found something markedly unhealthier and risky. 'Adrift'

captures HV lack of agency and struggle to make sense of their role, initially inspired by the in-vivo code of:

'Shady and shaky' HV3b.

'Shady and shaky' was originally the name of this category but was too vague. Shown in the context of the following quote the meaning is clarified:

'You don't see other professionals like GP's phoning and having to cancel like we have to and it just further undermines our role erm which is already really shady and shaky because they're not training HVs at the moment' HV3b.

HV3 uses *'shady and shaky'* to describe how she feels her profession is undermined, undervalued and underfunded. It is *'shaky'*, in comparison to other professions perhaps viewed as hierarchically more important. HV3 conveys contempt for the constraints that force her to cancel appointments. She does not want to practice like this and knows it is unhelpful but these *'shady'* or obscured elements, interfere with practice (linking to the lack of HVs).

Other codes related to ingrained and intractable problems, for example, prolonged family histories of domestic violence and continued exposure to extreme trauma or safeguarding:

'In and out of crisis' HV5a.

Experiences of danger in 'adrift' felt beyond HV capacity, codes related to situations out of HV control, often linking to how universal services have changed and something is painfully unfair:

'I couldn't hold her' HV5a.

'Not getting eyes on these children' HV3b.

'Noticing unfairness' HV3a.

'Unfair and unjust' HV4b.

Exposure to unfairness may relate to what HVs witness in families, for example, hearing a child say:

'I don't have friends because my toys are all dirty.' HV1a

Unfairness also connects to the service HVs provide and the organisation in which they work. These experiences make HVs feel party to something underhanded. Demonstrated in the following codes:

'The person doesn't matter' HV2b.

'Not given a choice' HV5a.

'Decisions are out of our hands' HV2b.

Codes in 'adrift' capture HV despondency in response to sometimes feeling ineffective:

'What difference am I making' HV2b.

Broken system

The theme of *'broken system'* relates to family/organisational processes and dynamics. It concerns HVs' experiences of working in inadequate systems. Sometimes these systems or dynamics create a sense there is no hope of change and practitioners merely wait for things to deteriorate:

> *'Just keeps happening' HV2a.*
>
> *'Feeling things won't improve' HV2a.*
>
> *'Escalating concerns' HV2b.*
>
> *'The damage has been done' HV2a.*

Other codes described the impact on HV capacity to prevent difficulties:

> *'Losing ability to prevent problems.' HV3a*

HV4 talked about new distinctions being made between those who get a universal service and those who don't, these circumstances are described in the following quote:

> *'There is a certain stigma around HV for some people…it's an 'everybody' service but we're already stopping that with anti-natals not being done for the more universal. So again you're starting that stigma for those that are having it, so, 'why is she having it and I'm not? And vice versa…Universal is key to safeguarding.' HV4a*

Many HV lamented the changes to universal services, explaining the loss had impacted on their capacity to provide help. These HVs' experiences related to codes such as:

'Giving up on a child' HV4a.

'Children living in chaos' HV2a.

Some HVs provided shocking descriptions of children living in deprivation, exemplified in the following quote:

'Horrendous home conditions and I'm talking horrendous, cat urine on the floor, utter utter filth and parents who won't engage with early help because they've had children removed in the past and those children are back at home and they're just frightened those children are going to be removed again.' HV3a

HV3's comments demonstrate a broken and damaged family system, these problems perhaps generational. The HV suggests this case will end with children being removed for their safety and thus breaking the family unit. This situation according to HVs undoubtedly impacts on the IMH:

'The process has an impact on the child.' HV2b

'Problems are caused through safeguarding process.' HV2b

HVs also pointed out how difficult it is for cases to meet the threshold for more services and safeguarding procedures. She explains:

'(I) hate that word significant harm, like harm is not enough it needs to be significant.'   *HV2b*

Other codes demonstrated the internal impact upon HVs working with these unhealthy systems:

'Sickness in the team.' HV2b

Or HVs wanting to leave the profession, described in the following quote:

'We're used to giving a gold standard service… We've been changed and we can't give that service anymore … and that's why a lot of people have gone because they want to give a good service. You're not in it to just tick boxes,' HV5a.

Overwhelming Anxiety

This theme concerns HV morale, codes related to HVs not feeling contained, which impacts their capacity to manage families' anxieties:

'Noticing everyone is overwhelmed' HV3a.

'Colleagues in a panic' HV4b.

This theme includes a painful list of worrying emotions HVs are exposed to on a personal level:

'Frustrated when things don't change' HV1a.

'Angry about procedures' HV2b.

'It's really sad' HV1a.

'Feeling responsible' HV3b.

'Feeling a failure' HV1a.

Codes revealed HVs' experiences of working with extremely challenging safeguarding situations and the effect this has on HVs' internal capacity:

'We're drowning and we can't do a good job.' HV3a

One such example from HV2 describes how she felt fooled and manipulated by a mother who was fabricating her infant's illness, the dyad subsequently becoming subject to child protection:

'I think for me it was betrayal … I felt like I'd failed him …we all felt that it was a case that had gone from feeling like we done a really good piece of work… I'd withdrawn from the case a bit because it was all going so well and she … was helping to facilitate peer led groups and all of these things.' HV2b

HV2 goes on to describe how this betrayal had far reaching consequences for her practice:

'I feel like I'm never going to trust anyone again and I think that... it definitely knocked my confidence and … I was doubting my own judgement…I couldn't even talk about it … without crying I probably cried for about three weeks every day.' HV2b

Codes also describe how HVs feel about lack of funding and staff retention:

> *'Worrying about staff sickness and stress.'* HV3a
>
> *'Telephoning families.'* HV3a

HV3 describes her overriding feeling in relation to her experience of organisational constraints:

> *'I just feel so embarrassed for our service and for myself; you know having to phone and say I'm really sorry I've got to cancel our appointment. It's now our Trust guideline that this appointment has to be done over the telephone.'* HV3b

HV3 explains how she feels the lack of training devalues the HV profession as a whole:

> *'I feel my job is worthless'* HV3b.

No capacity/under pressure

The theme of *'no capacity/under pressure'* concerns the overwhelming volume and intensity in HV practice. It contains a list of codes relating to the pressure HVs are under. Codes highlight HVs' experiences of struggling to fulfil their role or adequately to meet IMH needs, these include:

> *'Contact visits cancelled'* HV3b.
>
> *'Not enough capacity'* HV4b.

'We're time limited' HV2a.

'My diary is choc-a-block' HV5b.

'Wasn't in my remit' HV4a.

'No time to support families' HV3b.

These codes highlight how HVs are painfully aware how this may put the families at risk. This is unsurprising given the amount of families HVs have on their caseload, explained thus:

'you're looking at your diary and … thinking oh yikes ... You know, when there's, I don't know, a hundred new births that have come in for that month and you know all these members of staff that aren't at work,…you have to justify to your manager why you have to go back and see that family,' HV3b.

Furthermore, as a result, once HVs are actually in the family home it can be challenging to hold one family solely in mind:

'Thinking about other visits when there' HV3b.

In the interviews HVs struggled to put together coherent narratives around the families they wanted to describe:

'Finding things difficult to remember' HV3a.

These difficulties of feeling under pressure are explained in the following quote:

'And you walk in and you're thinking right, I've got four visits to do today and that doesn't include travel time, that doesn't include documenting. You know I'm working till eleven o'clock at night just to get records done ... So then when you do see a child that's presenting… with lots of tantrums and minimal eye contact … you then are sort of filled with a little bit of dread…' HV3b.

Some codes relate to parents lack of understanding concerning the seriousness of their child care, for example:

'Everything was fine from mum's perspective' HV1a.

'Pretend nothing is happening' HV2a.

Unsupported

The theme *'unsupported'* captures HVs' experiences of feeling as if they have nothing to hold on to. HV3 explains how she feels the HV service has been left unsupported:

'It's very much like nobody… wants to take hold, like support our service … I think because of the high caseloads, we've got stress issues, people are off, it affects morale it's a really vicious cycle and actually then families don't get the best of us, you know.'

HV3a

Other codes related to HVs' experiences of feeling unsupported by outside agencies:

'People undermining professional judgement' HV2b.

Other codes demonstrated the importance of supervision but in this category HVs feel there is no time to reflect:

'Too busy to reflect' HV3a.

This is exemplified in the following quote:

'There's nothing set up for sort of any clinical supervision any erm sort of reflective time or space in your diary to allow for that sort of debriefing,' HV3b.

HV3 conveys her sense of danger, feeling something is likely to go wrong. In this theme when HVs have time to reflect it is often only associated with safeguarding supervision. Furthermore, there was a mismatch between the support HVs want and what was given. This is exemplified in the following quote:

'I felt like she wasn't acknowledging how awful it made me feel, like she kept saying, "you know you did everything, you haven't done anything wrong. … I've been through your records." … I wasn't worried about that, cos I knew that what I'd seen was all documented … It was about that kind of personal…, what have I missed and what do I need to do,' HV2b.

HV2 conveys her manager's wish to deny the reality of the terrible situation and experiences she had. In the worst cases HVs received no support and the result is demonstrated in the following code:

'I didn't get a reply and I ended up … I went off sick' HV5a.

This theme also identified HVs' experiences of being witness to families not being adequately supported, for example, in the family unit when the HV has noticed an unsupportive father:

'*Dad seeing to his own needs*' HV5b.

Other *unsupported* codes concern HVs' experiences where a family's lack of support from the state could be detrimental to IMH, for example:

'*Mother and baby in a unit about to close*' HV4a.

'*Told breast feeding is easy*' HV1a.

'*(HV) taken away from a family*' HV4a.

'*Not getting seen by a HV*' HV3b.

The following quote from HV4 explains this in terms of IMH:

'*Services ... supporting mental health isn't enough, isn't qualified enough, isn't in depth enough,*' HV4b.

Isolation

The theme of isolation captures how HVs feel alone and unconnected from other professionals and colleagues. This collapse of support related to codes about, feeling unwanted and misunderstood. HV4 explained how she felt HV clinics were unwanted in the new 'posh' council building. Other codes included:

'Family better off without HV' HV4a.

'Can't see the point of a HV' HV4b.

'People not talking to HVs' HV4b.

'Decisions taken out of our hands' HV4a.

In this category, HVs' isolation extended into their experiences within their own teams, feeling alone with issues because they are aware their colleagues are also too busy:

'When you walk into the office and everyone has got their own issues there's nobody that's got any capacity to sit and have a cup of tea and have a conversation,' HV3a.

HV4 explained how other professions like midwives are often given gifts by families, coded as:

'HVs get nothing' HV4b.

HVs sense of isolation is also experienced when they are unable to connect with the families they want to support. Furthermore, sometimes families' request a change in HV and this can be felt as a rejection coded as:

'HV felt sacked.' HV4a

HV3 explains her frustrating experience of families' non engagement below:

'…they won't engage with early help because they see that as, you know another authoritative person, they won't answer my calls they're hanging up on me I can't get in that home,' HV3a.

Codes related to HV sense of isolation also link to HVs description of the baby's isolated experience. This was revealed in codes such as:

'Unresponsive babies' (HV1a)

Deprivation is drawn to this theme because children in this category are often isolated from the care they require. HVs witness children's deprivation through observation, as described below:

'I had gone round em just to do a routine review and it was cold, it was the winter and the baby was in a sopping wet nappy …she wasn't clean, the baby was dressed in just like a vest top and like a bottoms em and the same with the three year old and it was absolutely freezing. I didn't want to take my coat off in there. She (the mother) was sat with a warm jumper on.' HV2a.

This concludes the chapter on findings, which has described codes and quotes from HV interview transcripts. These codes were analysed using thematic analysis and the findings presented as themes and categories. In the next chapter, the discussion, the main topics from the findings will be interpreted and linked to applicable literature.

4   Discussion and Conclusion

This chapter explores each category and the interrelationships between categories. Salient key concepts from theory and research are linked to the findings and discussed. This part of the paper reflects on the researcher experience of interviewing participants. The final section focuses on what has been learned from this study, reflecting on the strengths and limitations and what recommendations could be made to support HV practice with IMH concerns. In addition, recommendations for further research based on the findings will be considered.

4.1   Explanation of Categories and Elements

Anchored

This category describes HVs being on task, in role, using knowledge and translating this into practice to support the parent-infant relationship. Several codes concerned HV relationships and experiences of a spectrum of emotions in response to families. In 'anchored', even when emotional interactions are highly charged, HVs work with and accept the limitations of their role. HVs sense of agency is strengthened by having time to develop reciprocal relationships, utilising universal resources and having consistent contact with families to monitor change. Furthermore, HVs recognise they may not know the right answer but can manage feelings of uncertainty. Feeling effective improves job satisfaction and meaningfulness in HV role and this, in part, is a result of being aware of emotional states in themselves and others. Helpful and supportive interactions in HV teams and good

working alliances with outside agencies, serve to underpin a relational equilibrium where HVs can both provide and receive support.

At the Edge

This category reflected risky parent-infant interactions, attracting the more challenging and traumatised families. Codes demonstrated the weight of responsibility HVs carry, alongside experiences of feeling in a battle with families and services. As exposure to external risk increases so does the HV's internal struggle. 'At the edge' encapsulates HVs crossing over into difficult, unchartered territory, encountering barriers from families or organisations and the difficulties around maintaining a distinction between work and homelife.

In 'at the edge', HVs face the tension and contrast between what they are able and want to provide and the reality of what will be delivered. This is compounded by high caseloads and complex parental mental health issues, bringing to the fore systemic problems such as, reduced universal services. Exhausting pressures and responsibilities, potentially create dangerous psychological work environments, HVs may be compelled into reacting rashly and more likely to feel responsible or blamed for failures. As a result, HVs may carry unprocessed emotions, impacting on their capacity to think, manage uncertainties and reflect. Codes relating to HV internal difficulties included experiences of feeling less confident in supporting maladaptive infant behaviour. Codes also related to increased confusion regarding role and a sense of meaninglessness. However, negotiating these uncomfortable realities is part of HV practice and essential to their role, this category provides evidence of the huge difficulties and pressure HV must carry.

Adrift

This category houses families with intractable, untenable and dangerous problems, who were often already subject to safeguarding processes. Codes related to endemic family problems and deprivation impacting on infant development. Families were less able to engage with HVs and often unable to make changes. Parents in this category often lacked capacity; they were in denial of problems and in danger of actually harming their baby. Exposure to families where it seems impossible to make a difference or that damage to the child had already been done impacted upon HVs sense of feeling effective.

HVs' experiences of feeling undermined and undervalued were also mirrored in the organisation, leading to codes capturing HVs isolation and rejection by families or services. Codes relating to systems in 'adrift' linked to the erosion of universal services causing some families to feel stigmatised if they accepted HV help. Being witness, party or subject to unfair or broken systems, ultimately affecting the child, appeared to create a sense of failure, hopelessness and dread. In psychoanalytic terms, these circumstances appeared to reveal a breakdown in the organisations container function impacting on HV practice. Enormous risk, along with overwhelming distress, sometimes not acknowledged by the service, left HVs feeling they had nothing to hold on to. These experiences were demonstrated in codes relating to having no time to reflect and in the worst circumstances HVs expressed a wish to leave the profession or go off sick because of stress.

Interrelating elements

Further exploration of how categories interrelate began another analytic process to find connecting elements between the categories and themes. This brought forth the

emergence of four elements present in each category at varying degrees. All the categories share four core elements impacting on HV practice. These elements are underpinned and influenced by risk, for example, when health visitors are exposed to risk, access to core elements needed to practice are reduced. The diagram below shows the four elements situated around the central variant factor of risk:
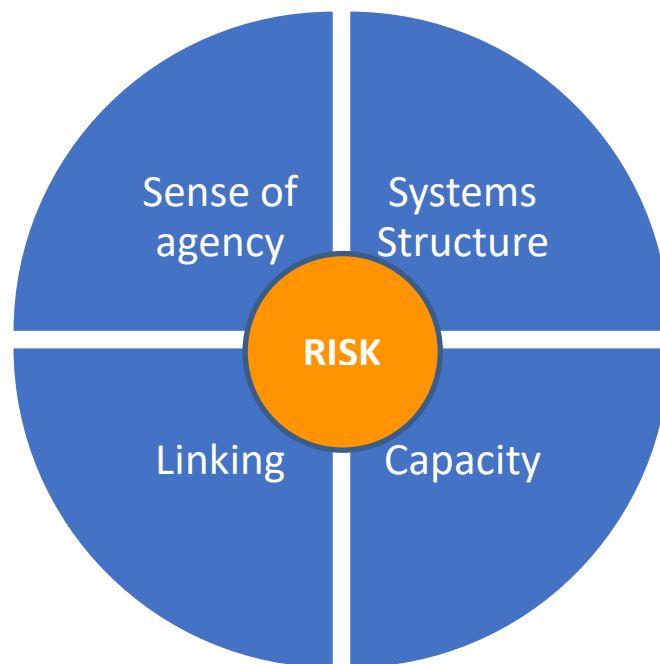
Figure 8: Diagram of four interrelating elements

These elements are described as follows:

1). 'Sense of agency' concerns whether HVs are 'on task', for example, in 'anchored' HVs know when and how to support IMH and are in touch with the limitation of their role but are aware of how to engage in multi-agency working to manage risk.   In 'at the edge' the HV probably has a sense they are off task or that the task is blurred or obscured in some way. In 'adrift' the HV may lose orientation to the task altogether.

2). 'Systems and structure' relates to HVs' experiences of working with families, safeguarding frameworks and support mechanisms in organisations.   Systems and structures provide scaffolding and this links to managing actual dangers. In 'anchored' HVs find systems are integrated, supportive and manageable but in 'at the edge' these systems are under pressure, conflictual and harder to access. In 'adrift' the systems and structures appear in breakdown or collapse.

3). 'Linking' concerns HVs emotional connections with families, colleagues, agencies, the organisation and the public. In 'anchored' HVs manage connections even when they feel challenged or uncertain. In 'at the edge' HVs experience barriers to connections and in 'adrift' there is little connection or linking.

4). 'Capacity' relates to time pressures, changes in and or volume of work. In 'anchored' HVs manage the volume of families, offer consistency and there is an acceptance of change. In 'at the edge,' HVs mentally struggle with caseload volume, feel less able to offer time and struggle with change. In 'adrift,' HVs experience lack of time, too many cases and a sense families and services are in a perpetual state of flux.

The categories and elements relate to situations and relationships HVs encounter, however by taking a reflexive approach and becoming more familiar with the data, it became apparent that these categories connect to different HV states of mind.   These states are impacted by risk and this challenges the four elements for effective HV practice. The core elements provide an internal and external framework and a decrease in mentally or practically accessing these elements ebbs away at an 'anchored' state of mind.

4.2   Health Visitor Relationships and Unconscious Processes

In addition to the relationships HVs develop in their practice, a unique relationship formed between the HV and myself as the researcher, where I became the product of the relationship (Charmaz, 2006). By the second interview, encouraged by the FANI method, HVs developed trust, described clearer narratives around the parent-infant relationship and this brought forth interesting dynamics. One example was HV3's discussion about a case that she felt impinged upon her home life, expressing it was too close for comfort. In the second interview she reflected on a particularly distressing family she knew I was involved with as part of my work in CAMHS. It seemed she unconsciously gave me an experience similar to her own, where my work, as researcher, crossed the boundary into my own clinical CAMHS work.

Through psychoanalytic reflection I came to understand HVs unconsciously identified with the child or the parent to help them instinctively know how and what to provide. This was similar to Winnicott's (1960) description of the necessary process of the mother identifying with her baby or Bion's (1962b) idea of the baby using projective identification, providing the primary caregiver opportunities to contain. However, this identification with parental projections sometimes went beyond healthy relational communication. HVs sometimes unconsciously acted-out families distressing projections as if they were their own. These uncontained feelings of frustration, failure, helplessness and dread were sometimes projected into the organisation perhaps as a defence against the painful realities HVs encounter.

HVs sometimes use emotive reasoning as a guide to respond intuitively (Benner, 1984) but this can become under the sway of countertransference responses based upon HVs own pre-existing characteristics (McCann and Pearlman, 1990). This is when HVs would benefit from a psychoanalytic framework around intuition which could be facilitated through psychoanalytic consultation.

4.3 Key Concepts within Categories

Bion's Ps↔D and Fluctuations between Categories

Bion's contemporary view of Klein's anxiety positions (1963) can be applied to the categories / states of mind which are not static and potentially provide structure to the minds of HVs allowing them to become observers to the vicissitudes of working with families in distress. To give extreme examples, if a HV feels they only practice in 'anchored' this could indicate a need to defend or deny distress. Conversely, if a HV feels 'adrift', this may not only be a sign of extreme family distress but a lack of internal and external containment.

In reality HVs fluctuate between the categories allowing for greater reflexivity, an open mind and capacity to reflect. This capacity is expressed by HV3 at the end of her second interview; she feels under scrutiny having to justify her visits, is frustrated that her professional judgement is undermined and feels this interrupts her capacity to practice. At this point HV3 is in a state of mind indicative of 'at the edge' and two of the core elements,

'capacity' and 'system structure' are under strain because of risk. However, HV3 regains an 'anchored' state of mind when she begins discussing the crucial early mother-infant relationship and her task of observing face to face interactions. HV3 says, 'we can make positive changes' and that HVs sometimes do not acknowledge how much they do because it is hard to quantify. The switch between these states is precipitated by HV3 regaining two of the core elements, 'sense of agency' and a capacity to 'link' with the mother-child relationship. This switch could also be as a result of her relationship with the researcher who provided a container encouraging HV3 to reflect.

Mentalization

The three categories / states of mind can be related to Fonagy's (1989) concept of mentalization. Mentalization forms through early attachment relationships and HVs use attachment language (Balbernie, 2013) making this pertinent to the categories. In health visiting, the process of mentalization informs problem solving, instilling the foundations for healthy relationships. The code of 'needing to find an inward road,' exemplifies the importance of HVs sensitively navigating their way into relationships and their reflective capacity with families. The relational value of mentalization is fundamental in this process and enhances capacity to influence others (Bandura, 2001) essential for developing agency.

Mentalization, closely links to Bion's concept of containment, this is at the heart of HV practice (Douglas, 2002) with HVs often standing in as a parent as part of their role. In 'anchored' HVs provide containment by absorbing family distress, providing a model for parents to build a secure base for their children. HV practice is in turn contained by the frameworks and systems in place to provide an effective service.

In 'at the edge', the capacity to mentalize is impacted by risk and a reduction in the four elements for HV practice. HV-parent relationships are more likely to be influenced by an anxious insecure/ambivalent environment and HVs may struggle to provide containment due to their own uncontained emotions. In addition, pressures, feeling unsafe and projections from the family reduce access to intuition (framed by clinical knowledge) and induce HVs to identify with family distress. In this state of mind HVs are at the junction between 'at the edge' and 'adrift' they can either find the resilience to manage risk by searching for an 'anchor' to enable relationship repair; or risk being pulled into more disorientating and less considered ways of relating in the category of 'adrift'.

Under enormous emotional and dangerous pressures, HV may find themselves in a state of mind which is 'adrift'. This relates to ambivalent/disorganised attachment environments where the prospect of thinking or containment seems impossible. This potentially non-mentalizing mode brings additional intersubjective risk where the HV may be perceived by the family as an unhelpful figure and this may be mirrored in the HV perception of the system they practice in.

Secondary trauma

Throughout the interview process every HV touched upon aspects of secondary trauma, this was often in relation to witnessing families in distress and the impact this had upon them psychologically. The explanation of the categories provides evidence that HVs' experiences of repeated empathic engagement with traumatised people impacts on internal capacities.

The capacity for practitioners to support those in distress can be considered on a spectrum, (Craig and Sprang, 2010) compassion satisfaction, compassion fatigue and burnout.

This research found when HVs are exposed to increased risk there is a reduced capacity in the four elements which orientate HVs to feel on task and in role. This can lead to isolation, feeling overwhelmed, helpless, guilty and confused. These findings are echoed in Machin and Pearson's, (2011) research which found inconsistent roles can lead to identity fragmentation, detrimentally impacting on optimum performance across a group and individually. The idea of role fragmentation also support the findings in this research, that HVs sense of confusion can enter their experience, blurring the emotional boundaries between themselves and families.

Particularly, in the state of mind linked to 'adrift', when work exceeds resources, HVs become more susceptible to emotional exhaustion and burnout. Burnout is related to a repeated sense of helplessness (Obholzer, 1994). This ineffectiveness sometimes mirrors families numbness and avoidance patterns which may have been adopted because of an inability to process traumatic material. When HVs reach burnout, morale and job satisfaction are impacted and they may seek new career options.

4.1 Strengths and limitations

A particular strength of this research is that it links to the government's vision of recognising the critical importance of the 'first 1001 days of life' (House of Commons Health and Social

Care Committee, 2019) and provides guidelines of how to support HV practice. In the county where this research was undertaken, this project tuned into the increasing aspirations of the Trust, statutory agencies and the third sector to develop a IMH service. Local HV leaders and NHS Trust Managers endorsed and supported this study and as part of this research existing working relationships between HVs and child psychotherapy were developed further. This research describes HV expertise and uses child psychoanalytic skills such as, infant observation/psychoanalytic skills and child development research knowledge to provide evidence of how HVs and child psychotherapists can complement each other's skills. This collaboration is of particular importance, if a new Parent-Infant Mental health service were to be developed in the county.

Another strength, is that this research is unique: in searches undertaken, no research could be found linking HVs and IMH. Research has been undertaken concerning the Solihull Approach (Douglas, 2002), by independent teams across the UK, measuring its effectiveness and how reflective consultation groups (Stephanopoulo at al., 2011), increase successful application of the model. However, this study provides an exploration of HV's real and present-day experiences, uncovering when HVs feel supported or unsupported in their work.

The word 'concern' featured in the research question and was included to focus the study on the more challenging aspects of IMH. This may mean more general experiences of IMH were omitted from HV responses. Nonetheless, by exploring HVs real experiences, this study gathered first hand evidence of how HVs feel about IMH of concern. The identification of states of mind provides unique markers, realistically reflecting experiences.

Findings demonstrate how HVs states of mind can be impacted upon by risk and this gives evidence of how risk impacts on HV practice. The simple categories, linked with fluctuating states of mind, offer a useful way to communicate unconscious processes and bring understanding to distressing experiences. In recent work with HVs I have had occasion to refer to these states of mind and HVs have immediately related to them and felt understood. I have also provided several debriefs to colleagues in another mental health setting. Their response to thinking about the states of mind, impacted upon by risk and the effect this can have upon unconscious responses, allowed practitioners to feel supported and relieved. This research provides evidence that HVs are impacted by secondary trauma and findings suggest that understanding unconscious responses to distress supports practice. Further research is needed to discover how best to provide this to HVs.

This researched employed the use of semi-structured interviews, in this approach to qualitative research the researcher has little influence on the data generated. Furthermore, due to the limitations inherent to a relatively small data set it is difficult to know how cultural / gender bias or if varied experience of HVs influence the data. However, individual factors or variables are less important in qualitative research as there is a descriptive answer. The application of the FANI method and thematic analysis provides systematic rigour, credibility and potential for generalisability. This means that the method applied could be transferred to other trusts and other professions/settings that work with mental health.

As it stands, this research is a small study, with a small sample size (five HVs) and only covers one county in the UK. The benefits of this allowed the data to be manageable and

explained in detail, while also providing something meaningful for this specific area. However, this also makes the findings impossible to generalise across the HV profession. More research would be needed to be able to compare with other samples. These samples would also need to demographically reflect ethnic minority groups and inner city working. Furthermore, other counties already have established IMH / perinatal mental health services or may have reflective consultation groups embedded in HV practice. These demographics, services and resources are not reflected in this research and may impact on HV's experiences of IMH providing different results.

4.2 Conclusion

This research investigated the experiences of HVs working with IMH concerns. Through the use of FANI and thorough analysis of data using thematic analysis, three categories were generated, 'anchored,' 'at the edge' and 'adrift'. These mental states provide an understanding of how HVs respond when core elements of HV practice, sense of agency, linking, systems/structure and capacity and are impacted upon by risk. HVs fluctuate between these states depending upon their ability to mentalize, however if capacity becomes impaired HVs become susceptible to secondary trauma.

Reflecting on my initial thoughts of where this research might take me, I considered I may discover HVs were apprehensive about working with IMH concerns, that they had skills but were not confident and if this was the case, skills could be learned. However, I was surprised how much the findings linked to secondary trauma and that there is a strong link

between IMH and risk and safeguarding concerns almost as if they are one and the same.

Furthermore, I had not expected that my simple question would uncover the important role

psychoanalytic concepts, such as Bion's Ps$\leftrightarrow$D and mentalization, play in understanding

HVs experiences. In the last chapter I will consider how these findings inform practice and

further recommendations for research.

5   Recommendations

Recommendations for Practice

This research provides clear evidence of the need to support HVs. Knowledge of secondary

trauma can support practice by providing understanding of why HVs experience distress

related to families and children's trauma.   Better understanding of secondary trauma

validates HVs abilities and does not judge HVs when things go wrong in families. Supporting

HVs to recognise fluctuating states of mind and that working 'at the edge,' grappling with

limitations and stresses, is an essential part of practice. Also for HVs to know there is a

stable 'anchored' state and an isolated state of 'adrift' can enable them to take action to

understand where feelings originate.

Despite there already being knowledge of secondary trauma across professions, HVs still

feel unsupported and this is no reflective consultation group in the Trust where I work. HVs

have safeguarding supervision provided by their team manager but research suggests

practitioners should also have access to supervision with a non-managerial figure who can

attend to their emotional wellbeing (Ruch, 2008).   Watson and Neilsen Gatti's (2012)

research found participants preferred an outside consultant. Reflective practice with a child

psychotherapist who understands unconscious processes and who can facilitate this, would therefore be extremely helpful.

Recommendations for research

To close the loop in this research, the next step would be to build upon HVs' experiences of having their role in IMH taken seriously and co-construct a mutual understanding around the findings. This research raises several questions, for example, investigating HVs response to this model and exploring if this could support practice. The important link to these findings is HVs' capacity to be reflective and reflexive to prevent the devastating impact of secondary trauma. Using findings from this research, a further study could investigate if knowing about states of mind, linked to secondary trauma, influences HVs mental health and work with families. This could be explored through a reflective practice group. For example, a research question could be, 'How does increased understanding of HV mental states, facilitated through a reflective practice group, influence practice.'

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7   Appendices

Appendix A: Participant Information

The Tavistock and Portman NHS
NHS Foundation Trust

NHS **Cornwall Partnership**
NHS Foundation Trust

Participant Information Sheet (interview)

> **Are you a Health Visitor interested in Infant Mental Health?**
>
> **Would you like a place to reflect and tell your story about how you respond to and think about Infant Mental Health concerns in your practice?**
>
> **Would you like to take part in research that will inform the Trust and wider audiences about the work of Health Visitors, their skills, work pressures and experiences of working with Infant Mental Health concerns?**

A qualitative exploration into Health Visitors' experiences of working with infant mental health concerns.

You are invited to take part in this research study. This information sheet tells you about the research, why it is being done and what it will involve if you decide to participate.

What is the purpose of the study?

I am conducting research into Health Visitors' experiences of working with Infant Mental Health concerns with children aged between birth and five. I am interested in Health Visitors' experiences and hearing stories of what it is like to work with families where there are concerns about Infant Mental Health.

Who Is conducting the study?

My name is Christine Volney, I am conducting this research as part of my Doctoral training in Child and Adolescent Psychotherapy. I am employed by Cornwall Partnership NHS Foundation Trust. My training is provided by the Tavistock and Portman NHS Foundation Trust in London.

What will participating in this study involve?

I would interview you and ask some questions about your experience of working with families where there are concerns about Infant Mental Health. The interview will take place at a time and workplace convenient to you. Participation will involve two recorded interviews, both lasting about an hour. The second interview will take place a week or two later and this will be to reflect on what was said and to expand on any areas of particular interest. Both interviews will be recorded and transcribed. Data for the research project will then be taken from these interviews.

The Tavistock and Portman NHS
NHS Foundation Trust

NHS
Cornwall Partnership
NHS Foundation Trust

Research Project Consent Form

A qualitative exploration into Health Visitors' experiences of working with infant mental health concerns.

Please tick the box if you agree to following:

☐ I confirm that I have read and understand the information sheet provided for this study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐

☐ I understand that my participation in this study is voluntary and that I am free to withdraw my data up two weeks after collection, without giving a reason. ☐

☐ I understand the interviews will be digitally recorded and then transcribed. ☐

☐ I understand that information given the interviews may be used by the research team in future publications, reports or presentations. ☐

☐ I understand that any personal data that could be used to identify me will be removed from the transcript of my interview and that I will not be identified in any publications, reports or presentations. ☐

Participant's Name (Printed): _____

Participant's signature: _____ Date: _____

Researcher's signature: _____ Date: _____

Thank you for agreeing to take part in this study. Your contribution is very much appreciated.

The Tavistock and Portman NHS
NHS Foundation Trust

NHS Cornwall Partnership
NHS Foundation Trust

Recruitment Advertisement

Are you a Health Visitor interested in Infant Mental Health?

Would you like a place to reflect and tell your story about how you respond to and think about Infant Mental Health concerns in your practice?

Would you like to take part in research that will inform the Trust and wider audiences about the work of Health Visitors, their skills, work pressures and experiences of working with Infant Mental Health concerns?

A qualitative exploration into Health Visitors' experiences of working with Infant Mental Health concerns.

You are invited to take part in this research study

What is the purpose of the study?

I am conducting research into Health Visitors' experiences of working with Infant Mental Health concerns with children aged between birth and five. I am interested in Health Visitors' experiences and hearing stories of what it is like to work with families where there are concerns about Infant Mental Health.

What will participating in this study involve?

I would interview you and ask some questions about your experience of working with families where there are concerns about Infant Mental Health. The interview will take place at a time and workplace convenient to you. Participation will involve two recorded interviews, both lasting about an hour. The second interview will take place a week or two later and this will be to reflect on what was said and to expand on any areas of particular interest. Both interviews will be recorded and transcribed. Data for the research project will then be taken from these interviews.

For more information about this study why it is being done and what it will involve if you decide to participate please contact: Email: christine.volney@nhs.net Tel:01726 873292 Address: Christine Volney Trainee Child and Adolescent Psychotherapist, CAMHS, Shaw House, Penrice Hospital, Porthpean Road, St Austell, Cornwall. PL26 6AB

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IRAS project ID: 250141

Appendix B: Ethics Permissions

The Tavistock and Portman **NHS**
NHS Foundation Trust

NHS
Cornwall Partnership
NHS Foundation Trust

Fieldwork Risk Assessment Audit

Name: Christine Volney	**School:** Tavistock and Portman NHS Foundation Trust M80 Doctorate
Student Number: 1507169	**Supervisor/ Director of Studies:** Dr Jenifer Wakelyn
Research Title: A qualitative exploration into Health Visitors' experiences of working with infant mental health concerns.	
Fieldwork Location: Various health visitor offices, children's centres and NHS buildings.	**Type of Fieldwork:** Face to face interviews with health visitors.
Proposed Dates of Periods of Fieldwork: Between September 2018 – January 2019	
Potential Hazards or Risks (Rate high medium or low)	
1. Angry response (low)	2. Physical /Verbal attack (low)
3.	4.
5.	6.
Potential consequences for each hazard Lack of safety for researcher	

Controls in place for each hazard in order of likely risk:
- ☐ The researcher will recruit via telephone calls to gain as much information as possible.
- ☐ The researcher is recruiting through health visitor team managers and health visitor team meetings. Therefore, participants are likely to be accessed through personal contacts.
- ☐ The researcher will adapt lone worker policies by telephoning a colleague before the interview and inform them of the address and expected leaving time. At the end of the interview the researcher will telephone the colleague to confirm they have left safely.
- ☐ The researcher will debrief with her service supervisor, particularly in view of the potential emotional impact of the interviews.

By signing this document, you are indicating that you have consulted this policy and have fully considered the risks.	**I agree to the assessment of risk in relation to this project.**
Signature of Student:	Signature of Supervisor / Director of Studies:
Date: 01.08.18	Date:

Risk Assessment Version 1.0 – 01.08.18   1
IRAS project ID: 250141

Ms Christine Volney
40c Bodmin Road
St Austell
Cornwall
PL25 5AF

27 July 2018

Dear Ms Volney

HRA and Health and Care Research Wales (HCRW) Approval Letter

Study title:	**A qualitative exploration into Health Visitors' experiences of working with infant mental health concerns.**
IRAS project ID:	**250141**
Sponsor	**Tavistock and Portman NHS Foundation Trust**

I am pleased to confirm that **HRA and Health and Care Research Wales (HCRW) Approval** has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications received. You should not expect to receive anything further relating to this application.

How should I continue to work with participating NHS organisations in England and Wales?
You should now provide a copy of this letter to all participating NHS organisations in England and Wales, as well as any documentation that has been updated as a result of the assessment.

Following the arranging of capacity and capability, participating NHS organisations should **formally confirm** their capacity and capability to undertake the study. How this will be confirmed is detailed in the "*summary of assessment*" section towards the end of this letter.

You should provide, if you have not already done so, detailed instructions to each organisation as to how you will notify them that research activities may commence at site following their confirmation of capacity and capability (e.g. provision by you of a 'green light' email, formal notification following a site initiation visit, activities may commence immediately following confirmation by participating organisation, etc.).

It is important that you involve both the research management function (e.g. R&D office) supporting each organisation and the local research team (where there is one) in setting up your study. Contact details of the research management function for each organisation can be accessed here.

Paru Jeram
RE: TREC approval
To: Christine Volney

25 September 2018 at 12:44   PJ

Dear Christine,

Apologies for the delay in my reply. Your application has been recommend and you may proceed with your research. Please note a formal letter will follow soon.

Regards,

Paru
Mrs Paru Jeram
Quality Assurance Officer
(Research Degrees and Research Ethics)
Academic Governance and Quality Assurance (Room 259)
The Tavistock and Portman NHS Foundation Trust
120 Belsize Lane
London
NW3 5BA
Tel: +44 (0)20 8938 2699

https://tavistockandportman.nhs.uk/research-and-innovation/doing-research/student-research/

See More from Christine Volney

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Appendix C: Second set of interview questions

HV1 – Question Set 2

In the last interview you talked about how you use observational skills to think about the Mother's capacity to be available for her baby and the emotional impact of becoming a mother. You also shared several examples of your experiences of working with IMH.

1. Have you any reflections from your first interview?

    - What was the experience like?

    - How did it leave you feeling?

2. When we met you were very honest and shared some extraordinary difficult situations you found yourself in as a HV connected to IMH

    - You were concerned about details you shared, perhaps having an idea you had communicated sensitive information and were unsure if it could be kept safe. I wonder what you think about that now?

3. Previously you talked about the importance of the HV relationship with the mother/family, the sensitivity required as a HV to help parents think about problematic interactions while keeping the child's needs in mind.

    - One of the things I have noticed when we start thinking about IMH, is that IMH can turn into safeguarding concerns or the way they are responded to is by safeguarding. I wondered what your thoughts are about this?

    - Do you think there is something helpful you have done in response to an IMH problem, did it make a difference, what helps and what doesn't?

4. In your role as a HV, in regards to IMH, what helps you manage your relationships with families and colleagues?

    - What helps and what makes it harder?

5. You see a lot of difficult families what helps you hold on to of the different families in your mind?

6. The previous interview made me think about the concept of a 'good enough' parent and the pressure to be perfect in regards to IMH. Have you any thoughts about this?
   - Does the concept of perfection intrude into your role as a HV?

7. Have you any other thoughts about IMH before we draw this interview to a close?

HV2 – Question Set 2

1. Have you any reflections from your first interview?

   - What was the experience like? How did it leave you feeling?

   - When we met you were very honest and shared some extraordinary difficult situations you found yourself in as a HV in connection to IMH. What was this like?

2. You mentioned something about people not always understanding the role of a HV in regards to IMH, for example, how much you are able to observe and glean from small interactions, like weighing a baby. I wondered if you could say more about what that it like for you?

3. You also talked about the tension between knowing what you would like to do to improve IMH, against sometimes feeling the limitations of your role. Can you say a bit more about what this is like for you?

4. You talked about the importance of the relationship with parents how finding opportunities to connect with them can take skill and courage and that this can sometimes make a change. Are you able to say any more about what this was like for you emotionally?

5. You also talked about how it can be distressing and draining when you think of the traumatic background of the parent, you see their vulnerabilities and something being replayed with their children and you can't get through to them to improve things. Can you say more about what it is like to try and keep the child's mental health needs in mind while also trying to connect with a traumatised parent.

6. In your role as HV in regards to IMH what helps you manage your relationships with families and colleagues?

   - What helps and what makes it harder?

7. You talked about the difference between peer supervision and safeguarding supervision, and that Safeguarding supervision can often make you more stressed. Following the neglect training there seemed to be an idea of another kind of supervision, can you say more about this?

8. You see a lot of difficult families what helps you hold on to of the different families in your mind?

9. You talked about families that play on your mind at home and there seemed to be a feeling that these families had crossed a boundary. Why do you think this happens?

10. The previous interview made me think about the concept of a 'good enough' parent and perhaps the pressure to be perfect in regards to IMH. In your role of HV do you have you any thoughts about this?
   - Does the concept of perfection intrude into your role as a HV?

11. One of the things I have noticed when we start thinking about IMH, is that IMH can often be tied up with safeguarding concerns or the way they are responded to is by safeguarding. I wondered what your thoughts are about this and how safeguarding impacts on IMH?

12. Have you any other thoughts about IMH before we draw this interview to a close?

HV3 – Question Set 2

1. Have you any reflections from your first interview?

   - What was the experience like? How did it leave you feeling?

   - When we met you were very honest and shared some extraordinary difficult situations you found yourself in as a HV in connection to IMH. What was this like?

2. You mentioned something about people sometimes undervaluing the role of a HV in regards to IMH, for example, how much you are able to observe and assess from small interactions and your wish to work more preventatively. I wondered if you could say more about what that it like for you?

3. You talked about the tension between knowing what you would like to do to improve IMH, such as, spending more time with families, against sometimes feeling the limitations of your role. Can you say a bit more about what this is like for you?

4. You talked about the importance of the relationship with parents mentioning how you sometimes put yourself in their shoes.   Are you able to say any more about what this was like for you emotionally?

5. You also talked about how the mental health needs of the parent can impact on the mental health of their child.   Can you say more about what it is like to try and keep the child's mental health needs in mind while also trying to connect with a traumatised parent.

6. In your role as HV in regards to IMH what helps you manage your relationships with families and colleagues?

   - What helps and what makes it harder?

7. You talked about differences you have experienced in the levels of support you have received as a HV as you have moved around the country. It seems at present there is limited time to reflect on low level cases of concern perhaps as opposed to

safeguarding cases. Also sometimes there is a feeling other colleagues are full up emotionally and you end up think about tricky cases at home.

Can you say more about what this is like for you?

8. You see a lot of difficult families and said you can have up to 500 families on your caseload, what helps you hold on to of the different families in your mind?

9. In the previous interview you talked about the old advise of controlled crying, that it creates a feeling of abandonment in the child and can impact on their future mental health. You mentioned your concern that some are still following this practice. I wondered what this made you feel like as a HV?

10. You mentioned motherhood can be seen with rose tinted spectacles. In your role of HV do you have you any thoughts about this?
   - Does the concept of perfection intrude into your role as a HV?

11. Have you any other thoughts about IMH before we draw this interview to a close?

HV4 – Question Set 2

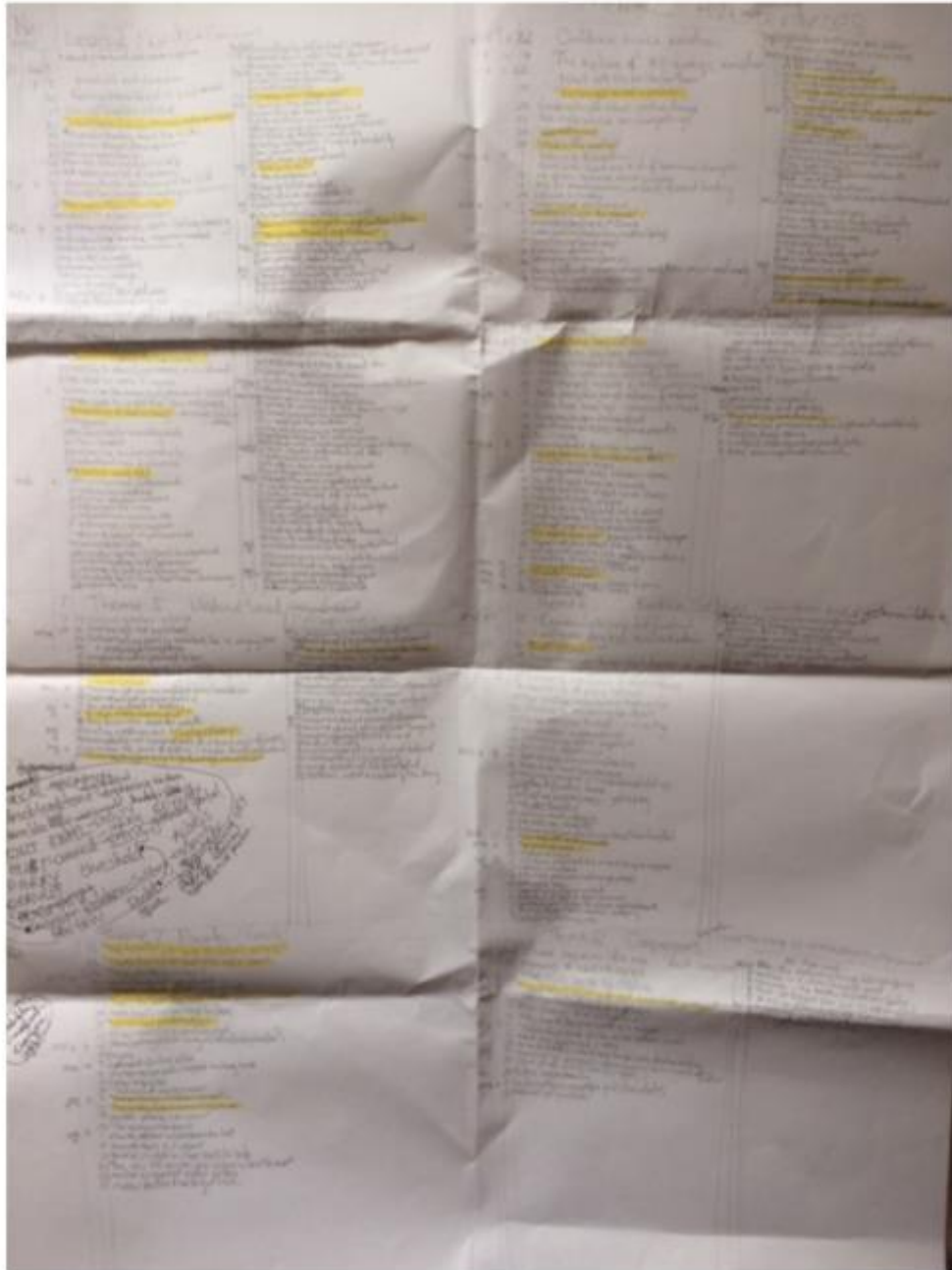1. Have you any reflections from your first interview?

   - What was the experience like? How did it leave you feeling?

   - When we met you were very honest and shared some extraordinary difficult situations you found yourself in as a HV in connection to IMH. What was this like?

2. You mentioned something about people sometimes undervaluing the role of a HV in regards to IMH, for example, your understanding of attachment theory, how you help mothers process their birth experience and that you do lots of things automatically without thinking.

   I wondered if you have any more thoughts on this now?

3. You talked about the tension between knowing what you would like to do to improve IMH, such as, having better universal services, spending more time with families, against sometimes feeling the limitations of your role. Can you say a bit more about what this is like for you?

4. You talked about the importance of the relationship with parents and children and that the emotional connection can be exhausting but may have keep relationships going. Are you able to say any more about what this was like for you?

5. You also talked about how the mental health needs of the parent can impact on the mental health of their child. Can you say more about what it is like to try and keep the child's mental health needs in mind while also trying to connect with a traumatised parent.

6. In your role as HV in regards to IMH what helps you manage your relationships with families and colleagues?

   - What helps and what makes it harder?

7. You talked about levels of support you receive as a HV, such as, monthly safeguarding supervision. You feel this is helpful but are not sure if it will continue and your time with colleagues in the office after the move to the council.
Can you say more about what this is like for you?

8. In your last interview sometimes it was hard to think of examples from families even though you had them in your head. I am interested in how hard it was to separate families in your mind, they merged together but when you are with them in the moment they have your complete attention. What helps you hold on to of the different families in your mind?

9. You mentioned how some mothers have high expectations of themselves, trying to be the perfect parent. In your role of HV do you have you any more thoughts about how mothering and perfection impact on IMH?

10. Have you any other thoughts about IMH before we draw this interview to a close?

HV5 – Question Set 2

1. Have you any reflections from your first interview? What was the experience like? How did it leave you feeling?

2. In the last interview you talked about the complexities around IMH and parental mental health sometimes feeling you didn't completely understand IMH and that you wanted more training. However, you also gave me examples of how you have used your understanding of IMH to support families by sharing observations about mother-child interactions and your understanding of attachment theory and brain development. We considered what do we really mean by IMH. I wondered if you have any more thoughts on this now?
   - Do you think there is something helpful you have done in response to an IMH problem, did it make a difference what helps and what doesn't?

3. You talked about the tension between knowing what you would like to do to improve IMH, such as, spending more time with families, against sometimes feeling the limitations of your role. Can you say a bit more about what this is like for you?

4. You mentioned how your work sometimes being in 'brief pockets' perhaps because of work pressure, families switching teams or families only tolerating a small amount from you.   I wonder how these brief pockets of work impact on how you see the outcomes of your interventions, can you say more about what that it like for you?

5. You talked about the importance of your relationship with parents and that without the anti-natal visit it can be hard for parents to take up your offer of help. For example the mother who you saw last week who had told you she was fine but you had a hunch things weren't. Are you able to say more about this now after you saw her the second time? - What this was like for you emotionally?

6. You mentioned what seems like keeping a balance between creating healthy working relationships with families and staying strong and protecting yourself from families trauma. For example, sometimes feeling overwhelmed 'having things put on your

plate' and things becoming personal and also the need to shake things off. Are you able to say any more about this now?

7. You talked about how the mental health needs of the parent can impact on the mental health of their child for example with the mother who feared abandonment or a child being labelled a difficult child.   Can you say more about what it is like to try and keep the child's mental health needs in mind while also trying to connect with a traumatised parent.

8. In your role as HV in regards to IMH what helps you manage your relationships with families and colleagues? What helps and what makes it harder?

9. One of the things I have noticed when we start thinking about IMH is that IMH can turn into safeguarding concerns or the way they are responded to is by safeguarding. I wondered what your thoughts are about this?
   - It seems at present there is limited time to reflect on low level cases of concern (in universal) Can you say more about what this is like for you?

10. In your last interview sometimes it was hard to tell me the background of the family but as we continued you remembered more information, what helps you hold on to of the different families in your mind?

11. You mentioned how helpful it can be when you advise mother's to 'bring the bar down'
    In your role of HV do you have you any more thoughts about how mothering and perfection can impact on IMH?

12. Have you any other thoughts about IMH before we draw this interview to a close?

Appendix D: Initial Mapping of Themes

Appendix E: Sorting of Categories

23 4b "It's the little things you're doing with huge knowledge behind them"   2 4b feel they can be the host

21 4b "I never stop saying just ring me"   11 Listening to mum

22 2 "deep understanding" - leading with a depth of knowledge   30 Family relationships

27 Relationship with a family - understanding family relationship

30 4b Praising parents with knowledge   16 4b Investing work into a family

26 4b Knowing when + when ...   4a 2 "The relationship is important"

25 4b Little things like weighing   28 investigation - exploring

12a Make sure to cover the key messages   29 questions to explore - finding out more

4 5b A need to question curiosities

27 4b Are you the mum you want to be at the moment

22 4b having knowledge gives comfort

24 2a trying to understand more   5 15 Visits focus on the child

44 5 managing change - emphasising parents responsibility   32 understanding the child's world

   20 bringing it back to the child

44 25 "strong position to support" a voice for the children

   2a focus is the baby and practical issues

34 a child's struggle - understanding the child's struggle

7a 4 Adult mental health connected with child's MH

13 see mothers are seen for thr/their issues on a 1st visit

ANCHORING

Emotional Connect

30 2a that's the first time I've felt anyone is actually spoken to me

31 2a feeling like he's accepted/liked to

26 KAL honest 3a needing to remain resilient

19 Questioning emotions - Assessing specific emotions

31 understanding knowledge of the future

4 1b The nature of HIV evokes emotion 3 1b Children evoke emotions

35 4b Mother disclosed her anger to HIV

39 having difficult conversations impacts emotionally

32 trying to explain intense feelings

32 past abusive relationships

33 2a understanding of frustration

3a 2 Accepting hopelessness - past coping

28 betting alongside families traumas

2a then there are lots of functional energy

4 escaping danger - feeling upset

23 family history - (risk!) - knowing a families difficult past

5 2a he often observe mums coping

5b Concerned about power difference

4 skillful in negotiation

18 looking at both sides - seeing both sides

26 deciding what's most important 'I really think this is important'

20 3 Feeling undermined "Shady + shakey" Pressure - Time
16 "don't have friends because my toys are all dirty" 5b "my diary is chocablock"
17 Acceptance Values - accepting time "management terrible"
30 Worried we're not getting eyes on these children 3+ 3b "can't support families"
4b Sneakiness, policing but it's not judgemental 5a "Feeling there are too many families
5b Grateful colleague was working late — Joint visit "more pressure" not enough people
rather aggressive to staff 4b Not enough "capacity"
Feeling suspicious about anyone else "getting bogged down"
5b The "Trust sanction" telephone appointments "I've never time for colleagues"
"Families have no problems" 3a 4 Assessing 100 births a month
5b "not get seen by a HV" — Nursery nurses do reviews Escalation. Films up Shane Panic
3b Had a student HV a couple of years ago "visits are cancelled" "we're time limited"
ANXIETY "you don't get the time you want" Under pressure
5b Need to "keep going" 3a dealing with things as they happen "It's really knee jerk"
5a "I feel out of my depth" 5a Feeling that only safeguarding provides time to reflect
Feeling sorry "little time to reflect"
Noticing everyone is overwhelmed "don't spend enough time with families"
Finding things difficult to remember 3b Working till 11pm to get notes complete
You "know this is horrible" 3b cancelling 6 week check for telephone app
Overwhelming emotions and no time Expressing how no HVs have time for a break
Filled with dread if discover "she wasn't in my remit"
Feeling responsible for making mothers wait Justifying time off — rearranging time
Just feel so embarrassed Feeling too busy to reflect
"hard work - to improve" No space
Frustrating when things don't change at home too busy
her visit was a worry / Worrying about visit pressured to talk about procedure
Feeling - "can't move forward think" - What else "I couldn't had her"
Thinking about "other visits" when there 5a 33
Feeling exposed to depravity "It was beastly"
Questioning calm body — stress "a lot on our shoulders"
Worried about staff sickness and school Meetings - "the person doesn't matter"
"lose control emotionally" Child protection most important
Feeling difficulties are to taken home Prioritising
Colleagues in a panic What's the most important task
Feeling pressured NEEDING MO
"It's really sad" Additional pressure when a parent needs help
Shady + Shakey Dad seeing to his own needs
 needing more from school
Battle — getting help - battling with manager for help
Mother vulnerable and exhausted Needs more intensive work
"miserable + frightened in a tiny house" "I can't take children out"
Bed wetting "long list of trauma"
Paranoia
shaky young mother with a poor childhood
complicated environment
history of significant domestic abuse having breakfast in bed - excuses

THRESHOLD

4 |M "underestimate the impact" 7|3|telephones are a barrier
3|2a "a switch went off" 8 |P "is that really meaningful?" Battle
3a |1b "What is the [role?]" 3|2b "what is my role?" 3b "You know there's a problem"
2a |achievement — get through the door 2a "you know this is horrible"
2b |4b Needing to find an inroad road 4a 43 | wrapped them up | shouldn't have done
2|2a Shouting as answering the door 4a 4 HV Delivered presents — Nowhere to store
3|2a Usually he walks away when HV arrives 4a | balancing between wk + children
2|2a Health visitors here — using phone
1|3a | for her monthly home visit work to balance mum's change
3|need a proper conversation 3|Moved to the plus team
2|2a entering to leave the shouting chaos 1|1b What will life be like for [child]
2|2a difficult to engage — "What it feels like for the children"
1|4b parents struggle to come back for help
1|2a visit for having severe but focus is breast feeding 3a | wanting to do more — a lot on our shoulders
1|3b telephoning when mum's are out
1|1a uncertain misunderstanding at first glance
3a | worried about costs that don't meet threshold
1|5b Worried about going off on a tangent 3a|4b HV took the "baby to soothe"
3a Worrying about decision making — having something else to consider 1|2a Need to check the baby's well
3|4b Encouraging the mother to feed her baby 2|4b + Mother roughly handling her
1|3b Encourage mothers to go to clinic instead — weigh baby 2a|a Not interviewed
3a 4b Explaining some family are more risky than others 4a | father engaging with HV
1|1b You learn, get solo in parents 2a defensive aggression
2|Birth — one of interview experiencing one of violence after birth.
1|5b A colleague wonders if it's domestic abuse
1|5b HV wants to explain what abuse looks like
1|1b Opportunity to help but trust
1|5b have a week to get baby weighed 12|a The baby is a distraction
1|(N) a | starting to think about difficulties 2b | parents who need extra help
3a | how to confide in HV friend out of work
1|5b Sought informal supervision with a friend asking about opportunities to reflect
1|5b Colleague knows the protocol 8|1b pointing out
4a | not unreasonable decision because of the jobs
1|Mum can't manage — knowing when a mother can't manage 5|trying
3|Observing children with difficulties 3a|Noticing vulnerable families 4b|Things
4a | talking about a child smelling 4a|2 weird feeding to remain resilient
5a |Noticing HV small pos its work 1|1b think you need a bit more support
5|22 Paranoia impacts on child behaviour 2a we often observe mums crying
4a | Prepared to challenge "Dad who wasn't an easy man 5|25 "I'm going to calm down
3a | Noticing unfairness but still needing to offload 5a | Other in crisis
3a | awareness of deprived areas 5a 21 Child picks up mother's paranoia
3| Older parents — Noticing older parents 5|1b You need skills 2|5a complex
4a 2 | "saddest girls I've ever seen" 1|5 how mother with a MH diagnosis
1|2a the little boy struggles to manage behaviour 5a 4 Want to be more confident
5a 28 Protect her child with her last breath 5a 5 training and information about IMH
5a 24 Mother adored her son 5a 5 have a better understanding IMH
5a 5 30% of HV training should be in MH
4| three children under 5 3a 2b Questioning whether a case is about IMH
1|Traumatic processes 5a No idea about MH until dealing with
5a 10 Mother with significant overlapping MH issues

COMPARISONS

35 | 3b I'm not the only one feeling like that!
5ª | Comparison to about my imminent services.

5ª | I understand what it's like to live in their shoes
7 | 1b KP I have my own little one 'don't compare'
1 | 3 could detach myself quite easily when I was more vulnerable as a mother
19 | 3° Other professionals don't phone or cancel appointments
3 | 4b comparison to district nursing - people give you chocolates'
16 | 3° identifying with mothers - Remembering what it is like

5ª 30 | As an A+E nurse I would have thought of a long seeing
8 | 1b don't compare long term opportunities 3 | so we've all feeling the same

EXCLUDED DEPRIVED   REJECTION   ALONE

15 | 5b Needed to "Lync" link   16 | 1b "was trying to sort the other one"
49 | HV tell "Sucked"   5 | 26 T wrapped in thought # suicidality
49 | during time out my school - Wanting to be involved   11 | 2b Phoning to cancel appointments
14 | 5b Feeling along with a risky family   4ª 14 | Father making a complaint
33 | 4b Mother in a mother + baby unit about to close 3 | 1b no we tried that it didn't work'
16 | 4ª not understand complaint compliant not explain   8 | 5b "my diary is choca block"
49 | I went particularly out of my way for 2 Christmas' to make sure they got staff 14 | 1a Batted back
25 | Rª father aggressive to staff - Joint visits   5 | 4b HV get the blame
49 | A senior worker said the girls were known   1 | 4b Midwives get presents
21 | 1b I don't have friends because my toys are all dirty   7 | 4b HV's get nothing
2 | responsibly lone for knowing history - No one else understanding   4 | 5b Dad seeing to his own needs
5ª 3 | feel my bad 'not being given a chance'   49 | felt angry frustrated + hurt weren't agreed to parenting work
49 1 | taken out of the family - taken away from the family   7 | 3b telephones are a barrier
5ª 35 | Manager felt knowing mother healthier   5 | 5b Dad tells us when he is going to the gym
28 | 3b thinking about other visits when there
5ª 20 | "You've going to take him away from me"
5ª 13 | "your not going to leave me are you" reluctant
11 | 4b "consistency of a HV" People don't understand
21 | 2a family had to another HV appointment
4ª 15 | Father telling family worker he is angry + HV

BROKEN SYSTEM   CHAOS

12 | Child protection responsibilities - past cases worsening ↑
5 | 2a living things more improve - long anticipates change
21 | 3° Currently not training HV's across the country
19 | 2a Observing Chaos - dad shouting at child
30 | Explaining Seeing a man collapse from OD   5 | 2b Whilst in the team
22 | 3° no training posts for a couple of years   44 | on child protection for 2 years
10 | Non-engagement let things happen / apathy   5ª 12 | "In and out of crisis"
40 | 5 living with a child inability to know issue + do 30 | having a drug overdose
11 | 1b long-term neglect and child protection   24 | no routines or boundaries
N | Chaotic - 1000's of police callouts   12 | been removed the worst thing to happen
34 | 2a being tired + coming home to chaos

Appendix F: Examples of Coding and Sorting

Table: Examples of Selective Sampling to Obtain Codes

HV	Line	Text from interview	Code
HV1a	Line 6	*She's getting the right support through our services, it might mean that baby is more settled*	Getting the right support aids infant mental health
HV1a	Line 16	*Maybe there isn't capacity for mum to manage anything else*	Knowing when a mother cannot manage
HV2b	Line 1	*those ones where you feel like concerns are escalating lots of your cases might be escalating*	Escalating concerns
HV2b	Line 8	*Someone was there but actually is that really meaningful and I keep having these battles*	Battling to stay with what's meaningful
HV3b	Line 7	*that barrier, I mean telephones are great but they are not like sitting down in somebodies lounge*	Telephoning creates a barrier
HV3b	Line 27	*To actually get through the door, you know we've made it, we've kept the appointment*	Getting through the door is an achievement
HV4a	Line 17	*I was just told, "well I think you need to be taken out of that family"*	Taken away from the family
HV4a	Line 43	*Maybe that was my fault I wrapped them up and I shouldn't have done*	Criticising self for protecting family
HV5b	Line 1	*I think she's low and she's got a mental health diagnosis historically*	Recognising maternal mental health difficulties
HV5b	Line 7	*I did feel there was a slight difference in power in that room so that's a concern*	Concern about power difference

Table: Examples of Random Sampling to Obtain Codes

HV	Line	Text from interview	Code
HV1a	Line 12	*Parents, it's a bit of 'well I did that,' and you've got to be skilful in how you negotiate*	Skilful negotiation
HV1a	Line 31	*The whole point of going into children's for me was about early intervention*	Wanting to provide early intervention
HV2a	Line 21	*So I arrived in the middle of chaos they'd forgotten I was coming …he was shouting as he answered the door*	Arriving to chaos and shouting
HV2a	Line 30	*He said "you know that's the first time I've felt anyone's actually spoken to me"*	Father feeling validated
HV3a	Line 4	*I don't feel there's enough support for families and for babies*	Feeling there is not enough support
HV3a	Line 16	*And end up having to speak to your family about how stressful work is*	Taking stress home
HV4b	Line 30	*I wanted to take the baby and soothe it and I did a little bit actually*	Taking the baby to soothe it
HV4b	Line 33	*Poor childhood experiences herself she is in a mother and baby unit about to close*	Mother experiencing deprivation
HV5a	Line 5	*Training should be in mental health because if we can deal with the adult's mental health we can help the adult to deal with the child's mental health*	Wanting training in mental health Adult mental health connected with child's
HV5a	Line 12	*In and out of crisis, one day we'd made a really good working relationship she was reliant on me*	Making relationships during crisis'

Table: Examples of Initial In-vivo Codes from Random Coding and Sampling

HV	Line	Text from interview – In-vivo code
HV1a	Line 21	*"I don't have friends over because my toys are all dirty"*
	Line 9	*Opportunity to help a parent*
HV2a	Line 4	*We're time limited*
HV2b	Line 3	*What is my role?*
	Line 5	*We've got a lot of sickness within our team*
	Line 17	*I know the background of the family*
HV3a	Line 20	*Further undermines our role which is already really shady and*
	Line 6	*shaky*
	Line 25	*A lot on our shoulders as health Visitors*
HV3b	Line 10	*We're not getting eyes on these children*
		I just feel so embarrassed for our service
HV4b	Line 23	*It's the little things you're doing those little things with huge knowledge*
HV4a	Line 22	*She wasn't in my remit*
HV5a	Line 7	*Complex mental health diagnosis with small children and I was like woe I feel out of my depth*
	Line 12	*We'd made a really good working relationship*
	Line 33	*I couldn't hold her*
HV5b	Line 8	*The conflict I have is my diary is 'chocablock' and I've got to find somewhere to put them in to support mum*
	Line 22	*I was getting bogged down in mum's mental health needs and not actually being there for the child*

Table: Examples of Initial sorting into Categories

Initial sorting	HV	Line	Example codes
Needs and concerns	HV1a	Line 30	*Children need routine*
	HV3a	Line 28	*Feeling suspicious*
	HV3a	Line 39	*Worried about cases that don't meet threshold*
	HV3a	Line 40	*Some families are more risky than they seem*
	HV3b	Line 8	*Needing a proper conversation*
	HV4b	Line 29	*A mother roughly handling her baby*
	HV5b	Line 2	*Mother vulnerable and exhausted*
HV experiences	HV1a	Line 4	*Underestimating the impact*
	HV1b	Line 19	*The nature of Health Visiting evokes emotion*
	HV1b	Line2	*You can get so lost in parents*
	HV2b	Line 22	*Feeling stuck*
	HV3a	Line 32	*Explaining intense feelings*
	HV3b	Line 14	*Feeling responsible*
	HV3b	Line 31	*Observing children's difficulties*
	HV5a	Line 22	*Observing impact of a mother's mental health on the child*
	HV5a	Line7	*No idea about mental health until dealing with it*
	HV5b	Line 21	*Any professional supervision is helpful*
Role/ responsibilities	HV1a	Line 2	*Measuring concern*
	HV1a	Line 4	*Listening to the mother*
	HV2a	Line 7	*covering key messages*
	HV2b	Line 12	*Linking maternal mental health to infant mental health*
	HV2b	Line 28	*Getting alongside family trauma*
	HV3a	Line 6	*Maintaining relationships with families*
	HV4a	Line 7	*Thinking about difficult families*
	HV4a	Line 24	*Being prepared to challenge*
	HV4b	Line 25	*Little ordinary things like weighing*
	HV4b	Line 6	*Making sure people have support*

	HV4b	Line 28	*Finding an inward road*
	HV5a	Line 16	*Thinking about child development*
Under pressure	HV1a	Line 12	*Little time to reflect*
	HV2b	Line 4	*What difference can I make*
	HV3a	Line 3	*Worrying about decision making*
	HV3a	Line 20	*Feeling there are too many families*
	HV3b	Line 26	*Not enough time with families to prevent problems*
	HV5b	Line 10	*Additional pressure when parents need help*
Misunderstood	HV2b	Line 17	*Focusing only on medical needs*
	HV3b	Line 20	*Feeling undermined "shady and shaky"*
	HV4a	Line 4	*Feeling left out*
	HV4a	Line 31	*Feeling sacked*
	HV4b	Line 11	*Can't see the point of Health Visiting*
Broken system	HV1b	Line 11	*Long term neglect and child protection*
	HV2a	Line 36	*Feeling things won't improve*
	HV3a	Line 13	*Noticing everyone is overwhelmed*
	HV2b	Line 2	*Children removed*
	HV2b	Line 5	*Sickness in the team*
	HV3b	Line 9	*Not being seen by a Health Visitor*
Family	HV2a	Line 37	*Never agreed to parenting work*
	HV4a	Line 24	*Dad wasn't an easy man*
	HV4b	Line 19	*Parents struggle to come back for help*
	HV4b	Line 35	*Mother is supported by her partner*
Comparisons	HV3b	Line 19	*Identifying with mothers*
	HV3b	Line 19	*Other professionals don't cancel appointments*