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Can the Parent Development Interview (PDI-RF) inform assessment in a CAMHs Parent-Infant Psychotherapy service? A qualitative study using Thematic Analysis.

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

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Abstract

The assessment is a core component of the process used by Parent-Infant Psychotherapists to ascertain the presenting issues, risks and needs of the parent/s and their infant to help decide if treatment is indicated or to make further recommendations.

This study aims to determine how feasible and acceptable the Parental Development Interview (PDI) is within the routine assessment and to understand its potential as an assessment tool in the service. By applying the PDI (Aber, Slade, Berger, Bresgi, Kaplan 1985), the parent's capacity for reflective functioning could be measured to ascertain if they can hold in mind their infant's thoughts and feelings. The objective is to incorporate the validated, manualised PDI (Aber et al. 1985) within the standard outcome measure sets currently used in NHS Child and Adolescent Mental Health Service Early Years Service.

It is proposed that the PDI could provide a sensitive, nuanced qualitative measure to capture key information on parental reflective functioning and the relationship between the parent and infant. Thematic analysis was used to analyse data from six semi-structured interviews of parent participants. Findings show that parents found the PDI useful and accessible to provide insight into their relationship with their infant.

Keywords: Parent Development Interview, Reflective Function, Experience, Standard Outcome Measures, inter-generational transmission.

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Abbreviations and Terminology

CAMHs	Child and Adolescent Mental Health Service
EYS	Early Years Service
PIP	Parent-Infant Psychotherapist
PPIP	Psychoanalytic Parent-Infant Psychotherapist
SOM	Standard Outcome Measure
RF	Reflective Function. Parental Reflective Functioning (RF) and mentalizing is a parent's capacity to reflect on his or her internal states, feelings, or wishes and the internal states, feelings, or wishes of their child.
Infancy	For continuity, I use the Baradon, Broughton, James, Joyce & Woodhead (2016) definition of 'Infancy' "as the pre-verbal period after birth to 18 months old, and 'parent' as either mother and father, or the primary caretaker and attachment figure" (p 30).
PDI	For the purposes of this study, I will be referring to the Parent Development Interview, also referred to as PDI-RF.

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Introduction

"Our efforts to try and understand both ourselves and one another are among the most natural and crucial aspects of human functioning"

(Slade. 2005, p5)

My interest in the use of outcome measures in Parent-Infant Psychotherapy (PIP) developed during my training when I was invited by the Lead Parent- Infant Psychoanalytic Psychotherapist (PPIP) to take referrals for the Early Years Service (EYS) in a Child and Adolescent Mental Health Service (CAMHs).

The Infant Mental Health workshop at the Tavistock deepened my interest in the different ideas and thinking in psychoanalytic work with the Parent-Infant relationship. Parent-infant psychotherapeutic (PIP) interventions encourage observation and play techniques informed, for example, by the 'Watch Me Play!' (WMP!) approach (Wakelyn 2019) and the 'Minding the Baby' programme (Sadler, Slade, Close, Simpson, Fennie, Mayes 2013). When pre-therapy work is needed with parents in a pre-reflective stage, WMP! is implemented in our service following an assessment and before PIP.

More commonly, mothers with moderate to severe mental health difficulties are referred to the PIP service where there is a concern her mental state is impacting negatively on the bond with her infant or unborn child from the point of conception, as can fathers who are struggling to bond due to mental health difficulties.

Referrals to the EYS can come from CAMHs colleagues, Health and Social workers, Midwives, GPs and community-based perinatal services and self-referrals.

The EYS pathway is for psychotherapeutic treatment of attachment difficulties possibly

caused by intergenerational trauma. Many families EYS work with as a specialist mental health service have complex needs. These difficulties can be enduring. It is often the case that referrals may require more than one type of intervention to help progress change.

Given the vulnerable nature of the EYS referral group, assessments include additional psychological factors such as anxiety, insecure attachment patterns, loss of self-agency affected by defences and self-protective strategies, developmental difficulties, and adverse childhood experiences (ACES). These can all harm the parent's capacity for the reflective functioning that is necessary to mentalise the parent-infant relationship.

1.1. Reflective Functioning

Parental Reflective Functioning (RF) relates to psychoanalytic concepts of mentalising. This is a parent's capacity to reflect on his or her internal states, feelings, or wishes and the internal states, feelings, or wishes of their child as a separate individual (Fonagy, Steele, Moran, Steele, & Higgitt, 1991; Fonagy, Steele, Steele, Leigh, Kennedy, Mattoon. & Target. 1995). Fundamental to reflective functioning are psychoanalytic concepts that prioritise the baby's first experiences of the primary relationship.

Reflective Functioning (RF) has been described as an emotional 'buffer' in that a parent’s sensitive response to their child's mental and emotional needs protects and promotes the child's development and well-being (Katznelson 2014, Grienenberger, Kelly & Slade (2005), Graham & Easterbrooke 2000 Malcorps, Vliegen, Nijssens,

Tang, Casalin, Slade & Luyten (2021).

The 'buffer' indicates qualities that can assure a secure attachment in the infant as a protective factor (Balbernie 2002b, p3). Parental Reflective Functioning (Slade, Grienenberger, Bernbach, Levy, Locker, & Kelly. 2001), based on the relationship between the parent and child, refers to how the parent thinks reflectively about their child and themselves as a parent. Another term is Mentalization (Fonagy, Steele, Moran, Steele & Higgit 1991, Fonagy & Target 1997).

Fonagy et al. (1991) discuss the link between attachment security and maternal sensitivity. This is the parent's capacity to understand the infant's state of mind based on a coherent mental representation rooted in the parent's attachment history (Barrows 2008, p116).

In their seminal review, Fonagy & Target (1997) focused on models underpinning the transmission of parenting attachment patterns and the influence on child development from pre-birth to 5 years old.

The building block of reflective functioning (RF) is the parent's capacity to recognise her child has his/her mental state (Fonagy & Target 1997, Slade 2005 p23, Baradon, Fonagy, Bland, Lenard & Sleed 2008). Barrows states:

> A central hypothesis in attachment theory is that parental representations of attachment determine parent-sensitive responsiveness and [...] in (its) turn affects the infant-parent attachment (2003 p5).

This, in essence, follows from Briggs's (1997) correlations between the mother's emotional preoccupations and the availability of her internal resources. The mother's

representation of the infant's state of mind can measure the mother's state of mind and availability to think about her infant. Briggs (1997).

Fonagy (1998) describes the mother's reflective function (RF) as a vital indicator of the infant's development of a secure attachment influencing a culture of change (James 2002, Jones 2006, and Barrows 2008). Improvements in maternal reflective functioning have been measured through videotaped interactions (Beebe 2003, 2010), questionnaires, and pre/post interviews using the reflective function scale. Qualitative evidence is described in several short-term, slow, open group studies with under-fives (Zaphirio-Woods & Pretorious 2016, Belt & Punamaki 2007, Reynolds 2003). Open groups enable new members to join at any time and may have no specific time frame. With the growth in empirical evidence over the past ten years (Sharp & Fonagy 2008, p737), research has promoted our understanding of the link between RF, child development and attachment in a social and environmental context. According to Katznelson (2014), psychotherapy research into the evidence supporting RF empirical measures in vulnerable parents still needs to be improved.

Klein (1936) was conscious of the baby as an individual, separate from his (sic) mother when she stated:

> The mother must realise that the baby is not actually her possession, and that, though he is so small and utterly dependent on her help, he is a separate entity and out to be treated as an individual human being; she must not tie him too much to herself, but assist him to grow up to independence. The earlier she can take up this attitude the better' (p300).

Drawing on psychoanalytic concepts of maternal 'reverie' (Bion 1962,1963), the concept of container-contained defines the mother's thinking mind as a container for the baby by making sense of her baby's communications. This provides the baby with

the capacity for thought. The concept of primary maternal preoccupation (Winnicott 1965, 1971) relates to the mother's involvement with her baby to the exclusion of all else and a vital phase in the baby's first months of life. This ensures sensitive nurturing in the mother's attunement to her baby's needs. The work of Fraiberg, Adelson, & Shapiro (1980) perceived 'the past in the present', carried through the relationship from parent to child (Baradon, 2010). This concept derives from the parent's past attachment history.

Fraiberg et al. (1980) explain how 'ghosts from the past' in the mother's mind intrude and take up residence in the nursery,[…]and present for two or more generations' (1980 p388). They describe how the baby becomes a 'silent partner' in the family's tragedy, burdened by the past from birth. This seminal research influenced theoretical thinking about the cycle of abuse, unresolved attachment trauma, and the compulsion to repeat (Freud 2014). In short, this underpins the concept of transgenerational transmission.

The occurrence of intergenerational transmission may indicate unresolved trauma from the past that impairs the capacity for parental reflective functioning (Fonagy 1998). The parent's reflective ability was initially termed 'maternal mind-mindedness' (Meins 1997). A mother's mind-mindedness is the propensity to treat the infant as an individual with a mind, an important factor in determining her ability to interact sensitively with her child. Mind-mindedness is distinct from but overlaps with the parental' reflective function' (Slade, Grienenberger, et al. 2001).

Similarly, the 'Theory of mind' (Premack & Woodruff cited in Sharp & Fonagy 2008)

encapsulates how humans attribute thoughts, feelings, ideas, and intentions to ourselves and others' behaviours. The broader concept of mentalisation also describes behaviours, intentions, and states of mind in relationships (Sharp & Fonagy 2008, p278).

There has been extensive research on reflective functioning to understand the core factors that affect the child's attachment.

While the extent of the literature on intergenerational transmission in trauma shows how parental reflective functioning links with the child's mental states, it is beyond the scope of this study to be included in any depth.

However, the Parental Developmental Interview (PDI) is a measurement tool with reflective functioning at its core.

1.2. The Parent Development Interview

The PDI is a validated assessment tool used in various settings and with different populations (Aber, et al. 1985). This measure consists of a semi-structured interview administered by a trained practitioner, as opposed to self-reported, and consists of 30 questions. It usually take 60 minutes to complete and is most often used to measure the pre and post effects on a psychotherapeutic intervention such as Parent-Infant group therapy.

Quantitative research into the use of the PDI manualised tool is prolific in measuring maternal reflective functioning, e.g. the predictive correlation between infants' attachment style and mothers' capacity for reflective function (Slade, Grienenberger,

Bernbach, Levy, & Locker. 2005a).

The PDI offers compelling outcomes that evidence the importance of the parent's reflective function. In a semi-structured interview used to measure Parental Reflective Functioning (Slade, Grienenberger, Bernbach, Levy & Locker, 2004), the PDI asks the parent to describe their relationship with their infant at the current time, with examples from daily life. Empirical research verifies the tool's replicability and credibility (Fonagy, Target, Steele & Steele, 1998).

The PDI measure has been researched to specifically examine the parent-infant relationship, maternal functioning, and attachment (Aber et al. 1985, Slade et al. 2005, Slade 2007, Sleed, Slade & Fonagy 2018). Widely used for assessing the caregiver's capacity for mentalising (Aber et al. 1985; Slade et al. 2005a; Sleed**,** Slade, & Fonagy. 2018 p1), the first study on the PDI, conducted in 1999 (Slade 2005a, p17) recruited middle and working-class parents.

The PDI is an adaption of the Adult Attachment Interview (AAI) (George, Kaplan, & Main 1985) and was developed by Aber et al. (1985). Findings from the Reflective Function-Adult Attachment Interview (RF–AAI) led to the development of the PDI. Fonagy et al. (1998) describe a strong correlation between secure child attachment by the infant's first year and improved parenting. The findings also show that reflective functioning informs levels of trauma, maternal sensitivity, and intergenerational transmission of attachment trauma (Slade et al. 2005a).

The Parent Development Interview (PDI) is described by Kennedy and Midgley (2007) as:

> A semi-structured clinical interview designed to elicit parents' representations of their child, their experiences of their relationship, and perceptions of themselves as parents. Unlike the AAI, the PDI is evoking current experiences and recent memories, and thus can be seen to be a more 'online' measure of present internal working models and reflective functioning capacity. As such, it can be used as an important tool in exploring the parent-infant relationship and the parent's mental representations of the relationship's different facets. Both the AAI and the PDI can be coded in terms of the interviewee's level of Reflective Functioning (Fonagy & Target. 1997, p121).

The PDI has been adapted for RF coding for parents with infants (Slade 2005a), toddlers, brief versions, and adopting parents (Steele 2003 quoted in Slade 2005a) in the context of infant development. Slade (2005a) explains, "It is easier to understand what a 2 or 3-year-old is thinking and feeling than a 6 or 12-month-old" (p 22). Because of this, evaluating the risk to infants can be tricky. The variables are considerable and may be more predictive of later life outcomes seen in adolescence rather than linking risk to results (Balbernie 2002a). Holding in mind young babies in the early stages of their evolving relationship, the parents' childhood experience may predict their capacity to reflect on their states of mind concerning their infants' state of mind. However, research results indicate that low RF mothers are unlikely to use their own internal experience to guide their understanding of their child's experience (Balbernie 2002a p23).

Some evaluation tools do not tap into the mother's unconscious communication Fonagy & Target (1997). An outcome tool can only support more in-depth exploration if it can pick up narratives on parental experiences. Stern (2014) points out that the parent's capacity for RF in PIP can dramatically affect change in the relationship between parent and infant (quoted in Ransley, Sleed, Baradon, Fonagy 2019, p569).

The semi-structured interview used in the PDI to measure the parent's reflective function and relational awareness of his/her infant provides more detailed information. The PDI interview is not a diagnostic tool but is understood to be a more sensitive and nuanced way of assessing reflective functioning and parental sensitivity. This could inform the assessment to trigger a referral for parent-infant dyads needing more specialist therapy input.

1.3. Rationale

The rationale of this study is to explore the feasibility and acceptability of incorporating the validated, manualised PDI with Standard Outcomes Measure (SOM) sets used in CAMHs.

Monitoring and measuring service user satisfaction and treatment outcomes follow the governmental strategy of 'No health without mental health' (DOH 2011). The use of pre-and post-intervention outcome measures in CAMHs has become routine.
Parents' experience of services and feedback has contributed to guidelines and driven service evaluations to deepen the understanding of responsive care (National Institute of Health and Care Excellence 2012). This is an ongoing directive in the NHS about Service Users as co-collaborators to ensure meaningful patient involvement. The parents' views on their interview experience and opportunities for feedback are key to this study, as discussed in the findings.

As it transpires, the PDI is not currently used in CAMH/PIP services, so there is a gap in measuring parental reflective function, specifically how the child is held in the mother's mind (Lowe unpublished thesis 2020). Young infants need to be thought

about, reflected on and held in mind by the parent. This can be communicated through the parents' behaviour, responses, tone of voice, and language felt to be affective experiences (Sleed et al. 2018, Fonagy & Target 2000).

If the PDI could provide a more detailed understanding of a parent's state of mind and their perception of their infant, it would help us gain more awareness of the underlying difficulties brought to the assessment. The PDI could contribute to this by helping the parent and practitioner tease out what issues and needs are present. How this affects the parent-infant relationship could help inform a more accurate assessment and service for the family. Outcome measures are important for the family to support access to the PIP service, demonstrate the effectiveness of the intervention or trigger a referral to another service.

As mentioned earlier, there is an emphasis on the assessment and evaluation of new mothers with infants aged between 0-24 months in terms of the impact of inter-generational transmission. Unacknowledged risk can remain undetected in some parents when measured by multi-choice closed questions, ensuring accuracy only when the patient is stable. In some parents, measures that tend to ask multi-choice questions can be navigated to ensure a favourable outcome (Cotton 2021). https://survivingwork.org/https://www.independent.co.uk/news/health/nhs-therapists-patients-manipulate-data- b1908629.html

In summary, the key information I am interested in exploring is the parent's capacity to reflect on the infant's mind and feelings as a separate individual. In other words, is the infant in the parent's mind and does the parents' upbringing influence how they

parent their infant? Intergenerational disturbance replicated in the parent's relationship with their infant may indicate unresolved trauma that may threaten to cause a disorganised attachment in the infant. Understanding this would help practitioners and parents locate the presenting difficulties in the assessment. Government policy drives initiatives in the NHS that inform PIP on evidence-based service provision and outcome measures, discussed next.

1.4. Early Intervention Policy Overview

The British government published the 'First 1001 days of Life' strategic report (2019) and states, "conception to age 2, is a critical phase during which the foundations of a child's development are laid" (ibid p3) http://committees.parliament.uk/writtenevidence/94046/html/.

The report explains the importance of life chances, which can negatively affect mental and physical health, school readiness, home life, and life span, and identifies parents and families as the source of safe, healthy, nurturing environments. The report encourages cost savings in early intervention, particularly during pregnancy. In 2009, the Healthy Child Programme was launched to improve outcomes and inequalities through targeted support (ibid p4). Although financial investment is key to delivering evidence-based interventions and is considered an investment in thinking about what is valuable, it purports that few rigorous evaluations exist that evidence relevant outcomes (ibid p16).

Barriers include the need for more reliable information and demonstrations of effectiveness in programme-based interventions, with a shortfall of specialist skills in some areas (ibid, p320).

The strategy recommends high-level measurable goals and setting out plans for improvement for families in the first 1001 days. The focus, amongst others, is the influence on the infant's health, not least the relationship between the parents and their infant (p. 39). In response to the First 1001 days inquiry, The Association for Child Psychotherapy (ACP) recommend that action to increase understanding of the infant's needs as a unique individual and any sign of withdrawal or delay be addressed as quickly as possible (p 10). The ACP describes how resources diverted from early intervention infant and Under-Fives services can have a detrimental impact on the capacity to undertake in-depth work, often leaving no early intervention resources for this referral group. Relieving distressing symptoms in the infant can shift the parent-infant relationship, encouraging a different, or more accurate, developmental path. One of the many strengths of such work is the rapid pace of change that is possible in the early stages of a baby or young child's life (p. 8).
https://childpsychotherapy.org.uk/sites/default/files/documents/ACP%20First%201001%20Days%20inquiry%20response.pdf

The infantile experience can stir up strong emotions in parents by their infant and makes learning from experience an enriching if intense time with possibilities for change (Urwin 2003).

The Early Interventions: The Next Steps independent report (2011) describes the impact on the health economy and recommends early intervention provisions for parents and infants in evidence-based programmes.
http://www.gov.uk/government/publications/earlyinterventions-the-next-steps--2

The Wellbeing Transformation Plan (2015-2020) outlines 'the need to develop and enhance Perinatal Mental Health provision, recognising that this is core to building better outcomes for mothers and their children at this crucial time of nurture and development' (p20).

Parent-Infant Psychotherapy recommends a tier 3 specialist CAMH service in this manifesto (Leadsom 2013, quoted in Lumsden 2017, p218). Tier 3 comprises specialist multidisciplinary teams such as Child & Adolescent Mental Health Teams. Problems dealt with here would be too complicated to be dealt with at tier 2 .http://implementingthrive.org/wp-content/uploads/2016/03/Thrive.pdf

The NHS Long-Term plan recommends the I-Thrive framework for system change (Wolpert et al., 2019) an operating model of mental health services that provides an integrated approach. Perinatal Psychotherapy is identified as a specialist service within this model. http://implementingthrive.org/about-us/the-thrive-framework/

Mental health problems in perinatal services are reported to cost £1.8 million annually, with 72% identified as coming from childhood adversity that can emerge in adolescence. The remaining 28% of costs relate to maternal health, with up to 20% of women developing mental health problems during the first year of motherhood (Brooke 2021). This drives practice, research, and policy for families experiencing complex difficulties (Barlow, Bennett, Midgley, Larking & Wei 2015).

It is estimated that '10-22% of women in their first year after giving birth experience post-natal depression' (Brooke 2021, Liberto 2012, Lucken, Lemery-Chalfont & Howe

2012 cited in Fonagy, Sleed & Baradon 2018). They also state that 'anxiety levels in the perinatal period increase in 4% of women, whilst 2:1000 new mothers in the UK develop mental health disorders' (Ban, Gibson, West, Fiaschi, Oates & Tata (2012) cited in Fonagy et al. 2018).

The National Institute for Health and Care Excellence, NICE (2021) reports that perinatal health and social care provision is a key priority in treating maternal mental health. NICE recommend qualitative research to judge the effectiveness, attentiveness, and awareness of service user's experiences and needs (Finazzi & Macbeth 2021, p2).

The 2022/23 NHS Long-Term Plan for Mental Health prioritises the development of Perinatal Mental Health Services. The plan outlines how one in four women experience mental health problems during pregnancy and 24 months after giving birth (p. 81).

Specialist perinatal services commissioned for moderate to severe mental illness pertain to PIP/CAMHs care pathway for parent-infant services. Access to services needs to extend beyond the first 1001 critical days as anxiety, mental health, and attachment difficulties can peak around 12 months, possibly triggered by the mother's return to work. Gaps are noted in accessing parent-infant evidence-based services, and an increase of 6% in parent-infant difficulties in the context of maternal mental health is reported. Mental health difficulties in partners also account for a need to access services. In new fathers, rates of anxiety and depression increase by 5-6%, for example, caused by birth trauma or the loss of a baby in the perinatal period (Brooke

2021).

The Institute of Health Visiting website states that 1 in 5 women are affected by mental health problems in the perinatal period, rates of depression in new fathers double the national average for men, and 122,000 babies in the UK live with a parent with mental illness. Also highlighted is the long-term impact on the infant before the age of one, which can influence emotional and behavioural development later in life.

Regarding Infant Mental Health, the Institute of Health Visiting states that a young child's capacity to experience, regulate and express emotions is 'synonymous with healthy social and emotional development in a secure relational environment' (Zero to Three 2001 cited in Zeanah 2009). This definition emphasises babies' capacities as active agents who learn to manage their emotions with their primary carers. Infants are born socially interactive, and their development is shaped by the dynamic interaction between their biological makeup and experience. Responsive relationships with consistent primary caregivers help build a baby's neuronal connections in the brain, regulate emotions and behaviour, and form secure attachments. These relationships are the foundation of mental health across the course of life https://ihv.org.uk/.

The Parent-Infant Foundation (PIF), which created the 'Rare Jewels' paper, reports on the need for specialist Parent-Infant teams and formed a movement from the First 1001 days government white paper to advocate for research evidence and lived experience to inform decision-making.

https://parentinfantfoundation.org.uk/1001-days/

The Child Outcomes Research Consortium, (CORC) states that 'assessing and monitoring the mother-infant relationship is a key quality standard in community perinatal mental health care provision. 'It may be the area that service users feel most relevant to the support they receive' (Royal College of Psychiatrists, 2013. http://www.corc.uk.net

The Royal College of Psychiatrists (RCP) recommends several measures, including the Mothers' Object Relations Scale short form (MORS-SF) (Milford & Oates, 2009; Oates & Gervai. 2003, 2018). Although validated, the PDI is not listed by the RCP (2013) as a standard psychometric tool. According to CORC, there is insufficient research evidence of the Parent-Infant relationship to recommend specific measures. This could account for why the PDI is omitted.

CORC considers that current psychometric measures used need training, are time-consuming, and need more research into the feasibility of conducting and rating reliably. To further evaluate the use of outcome measures, a broader discussion follows about the use of measures with psychometric properties.

1.5. CAMHs Standard Outcome Measures

Parents are invited to complete short standard routine evaluation measures at the point of assessment in the EYS. These are the Generalised Anxiety Disorder Scale (GAD-7) (Spitzer, Kroenke, Williams, & Lowe, 2006); the GAD-7 is a self-reported questionnaire to measure the severity of generalised anxiety disorders. The Patient Health Questionnaire (PHQ-9) (Kroenke, Spitzer, Williams 2001) is used to monitor the severity of depression and response to treatment (NICE). The Outcome Rating

Scale (ORS) (Miller, Duncan, Brown, Sparks, & Claud. 2003) is a Likert self-rating scale used to measure progress in particular areas of a patient's life over the past two weeks. These measures prioritise the parent's perspective and are used by the NHS to record individual changes.

Research conducted in 2003 reviewed the properties of the Outcome Rating Scale (ORS) (Lambert, Burlingame, Umphress, Hansen, Vermeersch & Clouse., 1996). These researchers point out the importance of outcomes to commissioners and policymakers. The argument posed is that valid assessment measurements that require training can be complex, time-consuming and costly to the extent they are rendered infeasible for many service providers and settings (Lambert et al. 1996 p91). It is recommended that brief, reliable and valid measures should be adopted. Furthermore, it is stated that:

> responding to funding source requirements and consumer demand, recent studies have explored how outcome evaluations can be used on an ongoing basis both to inform clinical decision making and enhance treatment effects. (ibid p92).

Lambert, Hansen & Finch (2001) cite two studies that found that 65% of cases at risk of an adverse outcome showed an improvement using outcome measures. They also note a survey by Miller, Duncan, Brown, Sorrell, & Chalk (2003) whereby a single measure used over a year showed a 150% improvement in overall effectiveness (p 92).

This suggests the positive bias for using measures; however, briefer does not necessarily mean better for the Service User experience. Urwin (2007) highlights the pressure to demonstrate service and intervention efficacy within Parent-Infant Psychotherapy.

Wolpert (2013) describes the contradictory unresolved aims of data set collection, informing generalisable findings versus individual care in implementing PROMs. Wolpert proposes data may do more harm than good unless if the evidence base on how to use PROMs in direct clinical work is developed. Patient Reported Outcome Measures (PROMs) assess the quality of care delivered to NHS patients from the patient perspective. Wolpert contends that practitioners need to learn how best to interpret and report the data safely, how often to use the data in clinical practice, and when not to use them. The NHS, Wolpert states, is not helped by Trusts "imposing measures without adequate input from clinicians and patients on the usefulness of these measures, the lack of appropriate information[…] or the inappropriate use of PROMs data as standalone measures of performance" (2013).

Emmanuel, Catty, Anscombe & Cantle (2014), who researched the feasibility of using goal-based routine outcome measures in a CAMHs unit, conducted a CAMHs-specific study. It is highlighted that despite adopting routine outcome measures, there is still some resistance from psychoanalytic colleagues who perceive psychotherapy as challenging to measure. What is measured may not be relevant to the changes that have occurred and may not discerned in the outcomes. The questions may place a time burden on participating parents. Nonetheless, many advantages are noted, such as clarifying the clinical intervention and providing more precise information with other professionals, triangulated with information from parents and the Multidisciplinary Team (Emmanuel et al. 2014, p179). Their cautionary advice is not to avoid evidence-based validated measures in this climate if clinicians are to demonstrate the effectiveness of service provision. However, guidance and recommendations are key to standardising outcomes depending on the specific situation, timing and rationale for

why the Routine Outcome Measure is valid and useful (Brooke 2021).

Measures can be instrumental in understanding how the patient views their situation, what has brought them to assessment, or monitoring their progression in therapy, but this can be hard to measure (Balbernie 2002a, p. 9).

Balbernie (2002b), quoting Berlin, 'O'Neil & Brookes-Gunn (1998), states:

> Early intervention service providers carry out intensive and emotionally demanding work. Their personal characteristics- especially their ability to be emotionally available and empathetic – and their training and work experience influence the ways in which they deliver services. (1998 p8).

Practitioners in CAMHs must conduct pre and post Standard Outcome Measures (SOMs) to gauge any benefits gained from generic psychological interventions. Within my placement, I carried out the measures as required but felt the answers were rudimentary and focused primarily on the mental health of the parent, rather than that of the infant, or indeed the relationship.

I asked the Lead Psychoanalytic Parent-Infant Psychotherapist (PPIP) if he believed the measures captured salient information needed for the PIP Service and if a more comprehensive assessment would be useful to understand the needs of the parent and infant and the problems causing concern. We scoped for other measures within the literature but found that the only tools currently implemented in the PIP service matched those in CAMHs.

To address EYS service development training, I was funded in 2019, along with my PPIP colleague, to attend the three-day Parental Developmental Reflective Functioning Interview training delivered by Michelle Sleed, RCT PDI researcher. I

received Inter-rater-reliability to code Parental Development Interview gold standard transcript sets from semi-structured interviews using the manualised evidence-based measure to assess parental reflective functioning.

I was inspired by the PDI training to consider whether it could be used to measure the parent's reflective function in CAMHs/EYS to provide useful assessment information for both parent and practitioner before treatment. 'Usefulness' is not easy to measure. For this reason, I chose to capture the experiences of the mothers interviewed using the PDI to acknowledge this aspect of the work separate from the more psychometric properties of Standard Outcome Measures.

I want to see if the results gained from the interview provide a more detailed understanding of the experience and internal reflections of the parent at the time of the interview. This could inform the psychological intervention by understanding the parent's state of mind and their perception of their infant. It could also help us gain more awareness of the underlying problems brought to the assessment.

According to Godoy, Davis, Herbie, Briggs-Gowan & Carter (2019), validated, normed assessment measures facilitate a developmentally sensitive assessment of emotional functioning (p261). SOMs record basic information and concrete results in terms of the difficulties and perceived changes. Deterioration may be misinterpreted due to a lack of justifiable outcomes in the data; instead, the results may evidence more realistic developmental insights into the patient's difficulties.

1.6. Parent-Infant Psychotherapy Measures

Parents can enter into therapy with a perception of their infant that is influencing their capacity to be responsive to the infant's needs or distress and vulnerability, which may tap into the parent's insecurities. Where risk may be evident in the parent's relationship with their infant, SOMs may not be so sensitive to hidden difficulties that do not conform to the structure of the questions.

In these cases, in-depth measures could support modifications in parents' perceptions of their infant and contribute towards a more accurate risk assessment.

In Parent-Infant services, Patient Routine Outcome measures (PROMs) are considered important to support the service and to understand the experience of the service parents receive. This may demonstrate the effectiveness of the intervention, potential areas of change, and inform work with parents and infants to promote early relationships (Fonagy et al. 2016, p. 100).

Research indicates improvements in implementing evaluations when a clear rationale is applied. Broughton (2016) purports how practitioners can use assessment tools as a valuable addition to clinical practice to help identify infants at risk of developing disturbance or delay (p121). A broader problem of assessing parents is the short-term window to understand presenting needs and whether specialist psychoanalytic psychotherapy interventions, such as PPIP, should be offered.

The PDI could flag up whether pre-parental experiences impact on parenting. This is relevant as the underlying causes of depression, anxiety and mental health problems

are often found to be intergenerational. Parents could repeat their parenting experiences in their relationship with their infant transmitted from their upbringing through their developing relationship with their infant.

Preliminary information from conducting and coding the PDI would give baseline measures to assess potential risk and change during therapy. This could also inform the length of treatment and improve service access. The benefits of this semi-structured interview and access to the PIP service are necessary factors considered in this study, which I look at in the next section.

1.7. Access to CAMHs services

Access to relevant services has a high threshold for mothers with severe mental health needs. Availability of services is limited, with only 45 PIP services in the UK https://parentinfantfoundation.org.uk and it is likely not to factor in the relationship between mother and infant or mothers with a lower threshold (Hill 2011).

I found no relevant papers directly addressing service users' access to PIP services or CAMHs in the UK. However, there were articles on the mother's experiences of acute perinatal services in the UK, but outside the scope of this study.

The NHS Long Term Plan states it will improve access to and the quality of perinatal mental health care for mothers, their partners and children by expanding access to evidence-based psychological therapies within specialist perinatal mental health services, including parent-infant interventions. Partners of women accessing specialist perinatal mental health services and maternity outreach clinics should be offered evidence-based assessment for their mental health and signposting to support. This

will help care for the 5-10% of fathers who experience mental health difficulties during the perinatal period (p. 84). Recommendations include increasing access to evidence-based psychological support and therapy, including digital options. https://www.longtermplan.nhs.uk/wp-content/uploads/2019/08/nhs-long-term-plan-version-1.2.pdf

Wakelyn (2012 citing Haywood & James 2008, Hillen et al. 2012) states that failures in mental health provision for children with high levels of need may be aggravated if there is a lack of confidence in services, lack of recognition of need combined with a lack of resources and specialist staff (p51). Balbernie (2022a), who purports the best results, is strengths-based and involves the parent focusing on empowerment. He quotes Barnard (1993), who describes an 'intervention gap' between what the services provide and what the families need (p. 9).

From data collated from London CAMHs-based surveys carried out by an Under-Fives special interest group, Urwin (2003) reported an underrepresentation of certain ethnic groups and babies under 18 months old. This was despite the concerns about the predicted detrimental effects of post-natal depression on infant emotional and behavioural development (Urwin 2003, p378).

The Education Policy Institute report ‘Access to children and Young People's Mental Health Services (Crenna-Jennings & Hutchinson 2019) considers mothers the most common group to suffer mental illness in England, precipitated by pregnancy and birth. With no national data evidence studies, authors suggest this is an estimate of 1:10 expectant and new mothers, and a third of children aged 0-15 living with mothers with

moderate to severe mental illness difficulties.

The authors link this to the mother-infant relationship exacerbating poor attachment, childhood behavioural problems, a 50% increase in difficulties performing at school, and negative impacts on adult mental health and wellbeing. This, in turn, affects future employability and attainment. Contributors to risk factors identified as disadvantage, social isolation, abusive relationships, and lack of support for expectant and new mothers, which they state "highlights the importance of early intervention to prevent the intergenerational transmission of mental ill-health[….]in the UK" (2019). https://epi.org.uk/research-area/children-young-people-mental-health/

1.8. Benefits of conducting the PDI.

A potential benefit of the PDI could be to help the parent and practitioner understand the need for an assessment after completing the interview. In addition, parents may be interested in their experience during the interview. They could find that answering the questions leads to greater insight into their relationship with their infant and parenting. The PDI questions are designed to be thought provoking and may generate more discussion in the interview as parents begin to think about their answers and their emotional responses.

Parents may benefit from the opportunity to be listened to and their experiences taken seriously by a practitioner showing interest in their life with a new infant. Parents would be supported to develop their awareness of their presenting problems and to learn more about the impact of their parenting on their developing relationship with their infant. Equally, the benefits of using the PDI as an assessment measure are three-fold in that they could include:

· A clearer idea of the parent's strengths and challenges to help their engagement in therapy and their capacity to reflect on and recognise parenting patterns that may impede growth in their relationship with their infant.

· The increase in parental reflective functioning is likely to have long-term benefits for the infant's growth and development in school readiness and general well-being at the time and in later life.

· To enhance the development of a small service by assessing risk in mothers and fathers referred to the Early Years CAMHs service.

Chapter 2 Literature Review

What evidence is there that the PDI is feasible and acceptable to measure reflective functioning in parent-infant psychotherapy?

To explore this question, I chose four core topics to provide an overview of the literature that considers each aspect of the question.

List of core topics

2.1. Parent-Infant Psychotherapy

2.2. Assessment in PIP services

2.3. Reflective Function studies

2.4. Applications of the PDI in different contexts

With the need for more evidence on the use of PDI in CAMHs, I researched literature exploring its use in various settings and with diverse populations and risk levels.

This overview combines the findings of literature retrieved from searches of computerised databases, hand searches, and authoritative texts (Bart, Green, Johnson, and Adams 2007).

I identified the range of relevant literature related to the topic. The following databases were searched: PEP Archive, APA PsychInfo, Cochrane Library, APA PsychExtra, and Socindex.

Search terms included:

Parental-Infant Psychotherapy, Assessment, Parental-Reflective Functioning.

From the expanded search results, 465:23 were relevant, and eight articles pertaining

directly to the study focus. To research parents' experience of and access to PIP services using the same databases, I included the following search terms:

-User satisfaction, parent, carer, efficacy, helpfulness. Engagement, experience, access. Parent-Infant Psychotherapy. Perinatal. Under-Five's. Infant-Parent Psychotherapy. Child and Adolescent Mental Health Services.
From the expanded search results, 10:2 was relevant.

I searched for additional sources of information in Primary and Secondary sources. Gold Standard Random Control Trials (RCT), handpicked articles, papers, reviews, book chapters, and unpublished theses.

I selected the articles most relevant to the literature by focusing on research that included the PDI, Parent-Infant Psychotherapy and parental reflective functioning.
I applied a date restriction between 1985-2021 as the main body of research was developed and conducted during this period. I refer to studies, primarily from the UK, but found research conducted in Austria, Israel, Scandinavian countries, and America.

2.1. Parent-Infant Psychotherapy

The Parent-Infant Foundation (PIF), when reviewing 'clinical interventions and evidence-informed practice', describes Psychoanalytic Parent-Infant Psychotherapy (PPIP) as rooted in psychoanalysis. A developmental attachment-based intervention with distinctive paradigms in infant mental health clinical practice concomitant with this is the aim of helping parents to reflect on how their experiences in the past and present may be influencing their relationship or view of their infant. PIF state:

> The psychotherapist models sensitive responses and helps the parent to interpret their baby's behaviour appropriately. Psychotherapy pays particular attention to the unconscious and non-verbal aspects of communication between parent(s) and their baby.https://parentinfantfoundation.org.uk/useful-resources/resources-for professionals/

A wealth of literature on Mother-Infant Psychotherapy (Barrows 1997, 2008, Daws 1999, Balbernie 2002, Baradon et al. 2016) has advanced clinical and research initiatives over the past 70 years, including the Tavistock Clinic Under-Fives service (Miller 1992, 2004, Hopkins 1992).

Infant Mental Health services demand a core of specialised knowledge and skills congruent with the wide range of risk factors and developmental issues that need to be considered (Balbernie 2022a, p9).

Parent-Infant Psychotherapy practitioners view the early relationship as evoking strong emotions and reactions in the present (Slade et al. 2005a). They can be a window of opportunity in a newly forming relationship, evolving, and open to change (Barrows 2008, Pozzi & Tydeman 2007, Slade 2005).

The theory underpinning the Parent-Infant Psychotherapy approach described by Pozzi & Tydeman (2007) is that the parent's experiences in childhood are re-activated, re-enacted, and then projected onto the child (p294). Emmanuel (2006, 2008, 2011) discusses the well-documented fundamental elements of psychoanalytic, observational under-fives work with parent couples developed by Bick (1964, 1969). Wittenberg (2008) describes short-term work that prevents dependency (via transference on the therapist) to avoid disturbing new intimate relationships (Emmanuel & Bradley 2008, p36). Specific aims over a five-week consecutive period

focus on the parent's childhood experiences projected onto the infant, informed by 'child-led enactments of crisis' (Emmanuel et al. 2008, p81). The parent-infant relationship is inseparable, so seeing parents and infants individually would counter the task of therapy within a familial system (Barrows 2008).

In a review of Parent-Infant Psychotherapy research, Barlow et al. (2015) identified eight studies, four with no control group and four with other treatment types, with 846 participants. A meta-analysis of 19 primary outcomes of parental mental health (depression) and maternal sensitivity (attunement), including child involvement, positive parental engagement, and child attachment, found no preferential differences between PIP and alternative interventions when comparing PIP with other treatment models.

2.2. Assessment in PIP services

Parent-infant psychotherapists describe having to respond rapidly to referrals because of the age of the infant and the urgency of need. As Balbernie states, ' babies cannot wait' (2002b p2). The Tavistock Under-Fives manualised Brief Parent-Infant Psychotherapy model, developed to address the specific area of parent and infant bonding, offers up to five sessions; this varies depending on need and severity.

Emmanuel (2006) discusses the particular aims and tensions in PIP work of holding both the infants' and parents' states of mind, the parent's capacity to function as adults (p5), enabling parents to reflect on this relationship and to see their infant as dependent but with a developing mind (Baradon, Fonagy, Bland, Lenard & Sleed. 2008, p36).

Parent-infant psychotherapy has long been a neglected service despite this age group. Wakelyn concurs that it is relatively rare for children under five to be referred to mental health services (2012, p. 51). I have found in my experience that under-fives are not thought by some colleagues to have mental health needs and, therefore, get overlooked. Understanding how the relationship is transmitted is key, and there is a notable increase in addressing interpersonal conflict hidden in parent-infant work (Barrows 2008).

In a PIP assessment, parents report their difficulties and perceptions of the problem in their interactions with their infant. The infant correspondingly communicates through behaviour and play, which can inform verbal and non-verbal, conscious and unconscious interaction. The infant is central in the therapist's thinking, with babies as participants in their own right (Watillon 1993). Urwin (2003) tells us that the distinction of psychotherapeutic work (with this age group) is the emphasis on thinking about the emotional life of the child and mobilising the development of phantasy (sic) as it reveals itself in the play and interaction within a transference situation (p376).

It could be said that the parent-infant relationship is the patient; hence, the parent and infant are seen together (Balbernie 2002a, p12). According to Lemma (2016), the psychoanalytically informed assessment aims to formulate the problem (p128). Lemma states that:

> ‘evidence-based practice has encouraged many practitioners to use research as a guideline for which treatment works best for a given diagnostic group[…]. It should be considered when formulating patients' problems and deciding on treatment interventions’ (p130).

Lemma (2016) suggests whilst RCTs provide compelling evidence, they bear little resemblance to the complex presentations encountered by clinicians with the patient

in the room (p130). The benefit of an evidence-based approach is that it reminds us of the need to justify our (clinical) decisions (Lemma p131).

Stern (1995) considers what he terms different ‘Ports of Entry': The parents' mental state, the infant's mental state, and the relationship between the infant and parent (Barrows 2008, p71). It is a system where one aspect can affect the other, possibly influencing the parental perception of their infant or the infant's enactment through challenging behaviours. 'Ports of Entry' describe ways of accessing the parent and the infant's internal world and, therefore, the internal relationship as components combine and affect one another. This may be seen in the infant's distress communicated through failures to thrive, with excessive crying and difficulties in sleeping, feeding, toileting, or weaning. In effect, if the parent externalises or internalises emotional disturbance it may impinge on the relationship in the present. This may be exacerbated by the parent's own traumatic experiences from the past.

Infant Mental Health services may include PIP as a specialist approach to address difficulties in the relationship between the parent and their infant. Practitioners are more likely to work with the concomitant unconscious relational patterns of relating and behaving (Barlow, Bennett, Midgley, Larkin & Wei 2015). These relational complications can affect attachment patterns by attending to reflective functioning in the parent.

2.3. Reflective Function Studies

Fonagy, Steele, Moran, Steele& Higgit (1991) aimed to discern if parental reflective functioning affects the child's development of a reflective self. They determine that low

reflective functioning corresponds with a disorganised attachment in the child. Using the Adult Attachment Interview (AAI) (George et al. 1985) and the Strange Situation response (Ainsworth, Blehar, Waters & Wall 1978), the researchers found a clear link between the parent's capacity to mentalise and the child's future trajectory of self-reflection and attachment.

In a mixed-methods study entitled 'How is a mother's state of mind and attachment transmitted from mother to infant?' (Slade, Sadler, De Dios-kern, Webb, Ezepchick & Mayes. 2005b), mothers, averaging 31.8 weeks gestation, in stable cohabiting relationships were recruited with 94% white participants, 3 African American participants, 1 of dual heritage background, 50% had studied to graduate level, and 41% had completed college. This was a highly educated, stable, middle-class population. The attrition rate was 21% (n=17) before the baby's first birthday.

Conducting evaluations twice during pregnancy and four times after the birth (Slade et al. 2005b, p286), the Adult Attachment interview was conducted at the second visit (George et al. 1985) and the PDI (Aber et al. 1985) at 10 and 14 months. The Stranger Situation response (Ainsworth et al. 1978) was conducted in the final visit at 28 months. Results concluded that the PDI effectively assesses a correlation between high RF levels and secure attachment in the infant, correspondingly, low RF levels indicated insecure attachment (Slade et al. 2005b, p292).

Slade et al. (2005a) conducted an empirical study using the PDI to examine the relationship between maternal functioning and attachment (p284). Forty mothers were interviewed at the pre-natal stage and again at 14 months. Significant results propose

that the mothers' early attachment experience is crucial in intergenerational transmission (2005a, p283). Slade (2007) conducted research investigating 'stages of reflection' in a low-risk parent mindfulness group, supporting mothers in pregnancy up to the infant's second year to enhance RF through the therapeutic relationship (p655).

Arguably, these studies lack representation of diverse populations given the high RF levels and low socioeconomic risk but give a baseline consistent with middle-class normative groups. The underrepresentation of diversity is addressed in later studies, suggesting more developing awareness of the importance of the impact of socioeconomic and socio-psychological factors influencing the research, which is discussed later.

Empirical research in longitudinal studies on the PDI focuses on diverse high and low-risk parental populations. Examples include a study conducted by Aber, Slade, Belsky & Crnic (1999) with a sample of mothers of sons. RF was measured using the PDI at 15 and 28 months. Grienenberger, Kelly & Slade (2005) researched the mother's openness to reflect on her infant's emotional vulnerability. Measuring the infant's attachment at 10 months using the PDI, the researchers considered the strength of emotions that can be activated in the mother when the infant dominates the parent's needs (p20) and likewise when the mother's needs dominate her capacity to respond to her infant's needs. Results from the PDI concluded that both the mother's behaviour and her ability to respond sensitively to her infant's distress can mediate between RF and attachment (p. 20).

Baradon, Fonagy, Bland, Lenard & Sleed (2008) piloted a seminal longitudinal Randomised Control trial (RCT) in a mother and baby unit in a UK female prison. Using a group work programme entitled 'New Beginnings', they recruited 75 mother and baby dyads in the control group and 88 dyads in the intervention group from seven ethnically diverse participating Mother and Baby prison units. The aim was to modify intergenerational cycles of disorganised attachment by enhancing the mother's capacity for RF using pre and post-programme 90-minute PDI semi-structured interviews (Slade et al. 2004).

Attrition rates were high due to mothers being released from prison or withdrawing from the study. Follow-up measures were not possible (2008, p351). The remaining mothers assessed before and after the group intervention had a two-month follow-up (2008 p355). Using a battery of measures, including the PDI and the Mother's Object Relations Scale (MORS) (Oates et al. 2018; Milford et al. 2009), no treatment effect change was shown in the MORS. The PDI was thought to enhance the mother's tendency to idealise their relationship with their infant when questions (possibly) felt threatening. The qualitative analysis identified characteristics of 'less open to change' (Cramer et al. 1988) or 'thought about honestly'. Other themes revealed role reversal in mothers, essentially the infant parenting the parent. The infant becomes a source of comfort and emotional regulation to help survive incarceration (Baradon et al. 2008, p361 citing Ruth-Lyons (2003). Role reversal is noted to be a critical factor in the development of disorganised attachments (Baradon et al. 2008, p. 361). This can happen when the mother has unresolved problems from her upbringing that leaves very little mental space in her mind for her baby (Balbernie 2022a) and can lead to severe mental health problems in adulthood (Fonagy, Steele, Steele, Leigh, Kennedy,

Mattoon & Target 1995).

Interestingly, the researchers describe improvements in maternal behaviour and overall quality of behaviour in the intervention group, though not in the control group. In addition, it was hypothesised that the infants would respond to this positively over time. In the study, the group effect was observed to influence and modify the mother's behaviours. A limiting factor of the study led to researchers surmising that a more long-term follow-up was needed to measure the benefits of the parent-infant relationship and that a two-month follow-up was too short to assess change fully (Baradon et al. 2008, p362).

Fonagy, Sleed & Baradon (2016) conducted an RCT research on Parent-Infant Psychotherapy with parents with high levels of socioeconomic adversity and mental health problems. In the lack of what they describe as credible research investigating outcomes from Parent-Infant Psychotherapy, they identify limits of small sample size in recruited participants with relatively low levels of socioeconomic deprivation and hard-to-reach populations experiencing complex familial pressure (2016, p. 100).

This UK study focused on mothers with disadvantaged backgrounds. Women with adversities are reported to be three times more likely to develop perinatal psychiatric problems than normative groups and can have adverse knock-on effects on parenting quality, child development, and attachment relationships (Ban et al. 2012; Collins, Zimmerman and Howard 2011; Gress-Smith et al. 2012 cited in Fonagy et al. 2016). The mother-infant pairs were allocated to standard and primary care treatment PIP (Baradon, Broughton, Gibbs, James, Joyce, and Woodhead. 2005) and control groups

with 38 pairs across four sites in England. All were identified as serving demographically diverse urban populations with areas of high levels of socioeconomic deprivation (Fonagy et al. 2016, p100). Infants were under 12 months old.

Researchers argue that relational mother-infant therapies may be the most effective method of relieving the impact of maternal mental health problems on children. Current parent-infant therapy intervenes at both behavioural and relational levels to address internal representations. RF can act as a key predictor of future neurological, psychological and social development (Nylen, Moran, Franklin & O'Hara 2006, Bakerman- Kranenburg, Van Ijzendoorn, & Juffer 2003, Sadler, Slade & Mayes 2006 cited Fonagy et al. 2016, p100).

Measuring the parenting capacity for RF is a "useful method for evaluating the effectiveness of treatment and potential areas of change" (Fonagy et al. 2016, p. 100)—however, emerging empirical evidence provided mixed results.

The hypothesis that PIP would lead to more positive outcomes than the standard treatment is a critical factor in the impact of complex socioeconomic, attachment, and psychiatric difficulties on infant development.

This RCT compared outcomes of PIP with secondary and specialist primary care treatment for parents with mental health problems and their infants (2016, p101). Follow-up assessments conducted at 6-12 months implemented the PDI (Slade et al. 2004) as the primary assessment tool.

The findings from this research study using the PDI indicate the potential benefits of PIP for improving mothers' psychological well-being, their representations of their baby, and the parent-infant relationship. Primary and secondary measures indicate improved emotional functioning at follow-up with highly significant outcomes for depression and maternal confidence (Fonagy et al. 2016, p109). The study concludes

> significant findings that the PDI on the RF and the ARR rating scales…did not reach statistical significance….the PDI scored on the ARR scale indicated a significant reduction of representational risk in the PIP group, but not in the control group (p108).

The author's state: "Contrary to prediction, the PDI did not reveal more rapid improvements in parental RF associated with the PIP intervention, although there was some improvement in both groups." (p109). There was some improvement in RF. Mothers demonstrated less helplessness and hostile representations towards their child over time. No improvement in this area was indicated in the control group (p109). Reporting on mothers' emotional well-being from PIP treatment, the researchers were surprised by the treatment impact measured using the PDI scale. They suggest distressed mothers use affect-laden language instead of mental state language of mentalisation. Mothers who idealise their infant tend to have concrete mother-infant representations (Sleed, 2013; Sleed**,** Slade, & Fonagy. 2018), which reduce the measure's sensitivity. They also note that validating the mothers' sense of competence in caregiving shifts from negative attributions to a more benign understanding of their infant's behaviour. This may be contingent on the therapy (Fonagy et al. 2016, p110). Limitations include:

- A small sample size.
- High attrition rates in young mothers.
- Low attendance rates in PIP.

- Diluting treatment effect for mother/baby dyads who engaged successfully in treatment.

Further research is recommended to examine findings from different participant subgroups.

Ransley, Sleed, Baradon & Fonagy (2019) researched the correlation between pre-treatment expectations and mothers' engagement in Parent-Infant Psychotherapy using mixed secondary analysis methods from two RCTs. The authors first qualitatively analysed the mothers' treatment expectations following participants' engagement in PIP groups (Ransley et al. 2019), then grouped these into quantitative categories, and looked at how expectations influenced outcomes, using the PDI amongst other measures.

Replication of two RCTs assessing 61 highly diverse parental dyads over 12 months, with different control conditions, used a mixed methodology, including the PDI (Slade et al. 2004) during the pre-assessment phase, with a 12-month home follow-up. Qualitative Thematic analysis (Braun & Clarke 2006) was used to develop themes and eight subordinate themes on intervention expectation: 1) to reduce mental health symptoms. 2) That the intervention would improve their relationship with their infant. 3) Uncertainty of what to expect, learning coping strategies. 4) Difficulties discussing past experiences. 5) Mistrust of services, 6) increased confidence. 7) Improve internal and emotional experiences, and 8) improve knowledge of child development.

Although expectations were not associated with engagement, the authors state:

> The most noteworthy finding is that improved RF was predicted by participants who held the expectations of wanting to improve their parent-infant relationship through the treatment, but who also expressed concerns about discussing their past experiences (p568).

Findings showed that whether the participant held positive expectations or some hesitancy, engagement did not influence the improvement in their reflective functioning in treatment (2019, p568). They also suggest developing a tool or questionnaire to use in conversation with patients before the PIP assessment (2019, p570). The PDI used in this way could inform the clinician and parent in assessing the significant issues needing greater attention, be this trauma, risk, or bonding.

2.4. Applications of the PDI in different contexts

Sleed, Slade & Fonagy (2018) analysed the importance of socioeconomic factors in low-risk, medium-risk, and high-risk populations concerning RF. The authors identified a link between parental behaviour and the infant's risk levels. This was determined by the degree of socioeconomic security and education that impact on parental RF.

Sleed et al. (2018, p1) state that little is known about the PDI's psychometric properties (validity and reliability), reasoning the need for more research on this tool. The research objective was to investigate if the coding system can be used with parents of very young infants across an age range or if the coding is just measuring the participant's level of education and intelligence (2018, p3). The researchers concluded that the PDI scale has good psychometric properties, evidenced by overall results. The researchers conducted a study using the PDI to measure the reflective functioning of participants in areas of socioeconomic deprivation. The results indicate the PDI coding is a valid and reliable measure of parental reflective functioning when used with parents from diverse backgrounds and differing levels of adversity (2018, p15).

The results from this study are relevant given the previous studies where low RF correlates with high socioeconomic deprivation and less access to good education.

An American study (Carlone & Milan, 2021) researched the level of parents' RF as a key predictor of whether the child needs mental health treatment. In this case, the researchers propose that children between the ages of 2-18 need mental health support and if access to Child Mental Health services is dependent on whether RF in the parent is lower or higher. This, therefore, informs parents of the capacity to recognise their child's difficulties. This study suggests that parental RF awareness of symptoms is a core indicator that could raise concerns. They linked parents involving specialist services with confidence in parenting and, subsequently, seeking clinical support (2021, p324). Consequently, parents with lower RF were deemed to feel less confident in their ability to understand their child's mental states or, indeed, less curious. The findings of this study using the Parental Reflective Functioning Questionnaire (PRFQ) (Luyten & Fonagy 2014) found that rather than parent's RF score determining parent's engagement with services, the influence on the scores suggest parental negative views on therapeutic engagement in pre-mentalising mothers (p322).

The PRFQ is a self-reported questionnaire, whereas the PDI (Slade et al. 2013 quoted in Barlow et al. 2021) is a semi-structured interview based on a coding system. As discussed earlier, parents may resist using services, possibly anxious their infant may be removed into care if risk is indicated, although, in reality, this is the last option taken. Although the PDI was not used in this study, researchers admit that the PRFQ does not consistently correlate with parental RF, whereas the PDI directly measures RF (Fonagy et al. 2016).

The PDI has been used in mixed-measure studies to evaluate the capacity of RF in substance-dependent mothers (Pajulo, Pyykkonen, Kalland, Sinkkonnen, Helenius, Punamakiir & Suchman 2012) to ascertain if improved RF acts as an agent of change in high-risk substance-dependent mothers accessing various interventions (2012, p 73). Using the PDI, the researchers found higher RF scores aligned significantly with positive change in mothers using drugs only, less so in mothers combining drugs and alcohol. Relevant variables included the substance type, education levels, and trauma experiences.

Several studies have used the PDI in various areas of practice to measure RF in mothers and fathers with substance dependency problems. Smith, Stover. & Kiselica's (2014) research on fathers with violence related issues used the revised PDI (Slade et al. 2004). Similarly, the Pajulo et al. (2012) study indicated lower RF in accordance with less education, socioeconomic factors and the type of substance abused. In another study, Glenne, Ingebjørg, Horndalsveen, S¨oderstr¨om, Ystrom & Håkansson (2020) saw the gap in examining substance abuse disorders (SUDs) in mothers and researched RF capacity in high-risk mothers. Using the PDI to assess RF, they concluded that the openness trait in mothers with SUDs is an important factor in this population that can affect maternal RF if mothers cannot distinguish their own mental states from their infants. Their view is that mothers with low RF would need psychological interventions to enhance their capacity to mentalise and adapt their approach to their infant's states of mind. Dyadic attachment-based interventions for high-risk populations could reduce potential disorganised attachments in infancy (2020, p. 32).

Ruiz, Witting, Ahnert & Piskernick (2019) conducted a 'first of its kind' study in Austria using the PDI to assess differences in RF between fathers and mothers of pre-term and full-term infants, having found limited empirical data on this specific area of risk. In this study, researchers recruited 322 parents of 173 children, of which 74 were 'pre-term'. Infants were between 12-20 months old. The participants were from highly educated middle-class families. Fathers' average age was 37, and mothers 35. Most fathers worked full-time. In addition, 59% of pre-term babies and 55% of 'to-term' babies' mothers took maternity leave (p3). Variables included the parent's gender and the birth status of the infant. Statistical evidence from this study showed no significant variant in the infant's gender, but the mother's RF score was higher than the father's, who scored lower in pre-term infants. Fathers were deemed preoccupied with daily care and entertaining their infants, whereas mothers thought more about infant development and meeting their infant's needs. This was considered to be due to the mothers being more present than the fathers in their infant's life in terms of the infant's development of mentalisation (p12).

The results indicate that the father's lower RF score is linked to their preoccupation as a means of managing their stress with a pre-term baby. They further concluded that using the PDI was useful in this context, but the study could have been more extensive, given the lack of diversity. Researchers acknowledged the results might be considerably different in low-income, single, same-sex or binational families with increased stressors (2019, p12).

Malcorps, Vliegen, Nijssens, Tang, Casalin, Slade, & Luyten (2021) report the need for RF measures designed explicitly for adopted families. They discuss the need to

measure RF, be it early or late adoptions, for families with a unique position of developing a new attachment with their child, likely to have a past attachment history. Steele, Henderson, Hodges, Kaniuk, Hillman, and Steele (2007) adapted the PDI manual for late adopters to take into consideration the sort of questions that parents may have on meeting their adopted child (Malcorps et al. 2021, p4). Many studies have used pre and post-intervention RF measures to assess possible improvements in biological parents. However, this study measured parental RF in pre-adoption families using a version of the Adoption Expectations Interview (AEI) adapted from the PDI.

Forming a relationship with a child who may have endured adversity (loss, separations, disruption, neglect, abuse) would suggest pre and post-adoptive parents could find RF a protective factor. As Cregeen proposes: 'adoptive parents can feel that it is not permissible to feel regret and hatred towards their adopted children, whilst in their private thoughts feeling just like this[…]can add to the guilty load'. (2022, p 239). The researchers conclude that studies conducted to date with adoptive families show that a more positive reflective parental stance towards the adopted child is associated with positive outcomes (2021, p3).

The PDI has been used with high-risk parental groups. Barlow, Sleed & Midgley (2021) conducted a systematic meta-analysis of parental reflective functioning in dydactic interventions. This review included RCTs to improve the parental function and interaction of parents with infants up to 36 months old, including high-risk mothers with high levels of social adversity, substance treatment programmes, and women incarcerated with their babies. All were either first-time mothers or pregnant women.

This, the first study of its kind, analysed six relevant studies implementing specialist psychotherapy interventions that measure RF outcomes of parental interaction (Barlow et al. 2021). The findings propose that interventions focusing on improving attachment-based needs and sensitive parenting can have long-term benefits (2021, p. 28). Researchers qualify that studies were of 'moderate standard', and that of the 521 Parent-Infant dyads, only borderline but encouragingly significant improvements were evident in RF using the PDI scale in interviews. Key to this are the mechanisms of change increasing parental responsiveness and sensitivity. Also considered are parents' capacity to mentalise their own and their infant's states of mind and their emotional experiences to minimise disruptive behaviours that underlie attachment disorders (2020, p. 31).

The review states that intervention effects (sic) did show sensitivity to treatment change (Barlow et al. 2021) but not parental mental health, as the samples were heterogeneous and numerically small. They did identify one study explicitly targeting mental health (Fonagy et al. 2016) that demonstrated positive outcomes but thought parents had pre-existing mental health problems rather than treatment interventions targeting parents with mental health difficulties previously unknown (2021,p31). Despite the study's moderate evidential improvement focusing on parental mental health and RF progress, the review linked positive gains in maternal depression. The authors discuss the importance of measures that capture intergenerational transmission following post-natal interventions in high-risk parents (2021, p22).

These are promising findings for high-risk parental groups who need access to specialist services. This supports mental health difficulties, increased parental

awareness and sensitive responsiveness towards their infants. The potential outcome in long-term benefits is to lower the risk of disorganised attachment patterns.

The PDI was incorporated as an outcome measure in a parenting programme, like Lambert et al. (1996), Borelli, Smiley, Kerr, Buttitta. Hecht & Rasmussen (2020) concur that the PDI is time-consuming, labour-intensive, and expensive to conduct and code in favour of the Parental Reflective Function Questionnaire (PRFQ) (Luyten et al. 2014). Researchers Menashe-Grinberg, Shneor, Meiri & Atzaba-Poria (2020) acknowledge that empirical studies using the PDI showed an improvement in PRF-based interventions. These include Pajulo et al. (2012), Sleed et al. (2013), Stacks et al. (2021), and the Menasha-Grinberg et al. (2020) study investigating maternal RF in a weekly group intervention called the DUET parenting model. This model is adapted from the reflective parenting programme (Grienenberger et al. 2004). Researchers focused on increased RF in Israeli mothers to develop positive interactions and decrease child behavioural problems (Grienenberger et al. 2004, p5). The principles of enhancing RF to prevent childhood mental health problems (Fonagy et al. 1998) were applied, as were Slade's (2007) ideas on how RF model representations of the child's mental states reflect the parents. They encouraged parents' curiosity in themselves and their child through in-depth, meaningful group exploration of thoughts and feelings. Results positively indicated that the PDI effectively accurately scored complex and in-depth aspects of RF. Measured using the PDI findings, changes examined following the DUET programme (Menasha-Grinberg et al. 2020, p14) demonstrated positive improvements in parental RF.

These results indicate how sensitivity in PDI coding enhances the researcher's findings and is feasible to use with a wide diversity of participants in a group programme. Results also suggest that uncontrolled variables in groups increase positive peer role modelling.

2.5. Conclusion to the literature review

From the literature, a range of themes emerges that indicate some differences of opinion about the PDI being time-consuming and expensive on a practical level but also providing a rich data source when conducted with a range of participant groups in various settings.

Arguments from the literature review show a gap in research on the routine use of the PDI to increase insight into the feasibility of implementation in PPIP/CAMHs. The gap in research literature indicates using the PDI as an assessment tool is not standard in CAMH services. The literature demonstrates the use of the PDI has long-term benefits, particularly in the context of PIP services to improve attachment-based needs, increase sensitive parenting, and measure the mechanism of change by developing RF (mentalisation).

It is important to know if using the PDI support the experience of parents why research in this area is important and if the PDI could be used routinely to meet the needs of parents and carers and the service.

The disparity between self-reported questionnaires and semi-structured interviews administered by trained clinicians indicates that self-reporting can be distorted,

whereas interviews may capture unconscious and lived experience responses in the moment.

More evidence is needed as the current research into outcome measures is limited, generally indicating insufficient evidence to support recommendations. Some studies support implementing the PDI to measure parental openness and as an agent of change in high-risk mothers. This theme recurs as an important indicator of the infant's development that can be either enhanced or impeded by the mother's mental health and capacity for RF. A lack of this capacity may generate problems in adolescence in the longer-term trajectory. Thus, there could be long-term benefit if low-risk-high RF and low RF-high risk correlations can be identified in assessment. The intention of improving the parent's understanding of their unconscious states of mind and the influence of intergenerational trauma transmitted through to the parent-infant relationship stands out in all the research.

Themes in the studies pinpoint the importance of identifying risk through measures and considering how risk can be lowered in vulnerable parents. This is highlighted in studies where the PDI has revealed parents' tendency to idealise the relationship and role reversal where the infant is used to comfort or parent the parent. Where openness to change is limited for several reasons, including parental infantile emotions influencing infant development, environmental factors, mental health difficulties, substance dependency or risk, the PDI seems effective in detecting the impact of low RF on the parent-infant relationship.

Several studies indicate improvements in specific areas of functioning reported by PDI outcomes that support the infant's later life resilience and awareness of the infant's thoughts and feelings.

The financial cost and time commitment considered a disadvantage in low-impact research are outweighed by the benefits, illuminated in studies that show improvements in mothers' depression and mental health, emerging disordered personalities, and early prevention of disorganised attachment in childhood. This would suggest that the research evidence presents a strong argument that resources are made available to conduct the PDI in PIP services as a cost-saving advantage. The figures would appear to speak for themselves. Balbernie (2022a) states that CAMHs are expected to deal with the fallout of the behaviours that demand responses in the aftermath of insecure attachment disorders in the child.

The literature discusses the variants of sample groups measured using the PDI, but no examples of research studies have used the PDI as an assessment tool. From the literature, the PDI psychometric properties do capture information on RF. I aim to address a gap in the literature in relation to capturing and investigating participant experiences of the PDI. This was not explored by the studies I have reviewed. For this reason, my interest in the present study is focused on the experiences of the participants and the researcher's experience.

Chapter 3 Methodology

3.1. Research context

Public health services now routinely use standard outcome measures to give pre and post-intervention baseline information to ascertain whether treatment benefits service users.

Parental experience of service and their feedback have contributed to guidelines and driven service directives and evaluations to deepen the understanding of responsive care (National Institute of Health and Care Excellence 2012).

The service where this study took place has a low socioeconomic population with mental health needs. People of diverse ethnic identities are under-represented in the service, although well represented in the staffing group. According to Income Deprivation Affecting Children Index (IDACI) (2019) statistics, one-third of the population is non-white, with 10,000 children living in poverty in the region. Of the children aged 0-15 in poverty in the area in 2021, 1,567 (29%) were aged below five. Nationally, this region is in the mid-range on IDACI, ranking 148 of 317 English local authorities.

The parents who participated in the research were from similar working to middle-class backgrounds and were representative of my socioeconomic status and identity as a white female. The setting is an NHS Child and Adolescent Mental Health service environment with dedicated clinical rooms. Participants would expect to come here for therapeutic treatment if indicated by the assessment. The CAMHs assessment is a core component of the EYS to ascertain the presenting issues, risks and needs of the

parent/s and their infant to help decide if treatment is indicated or to make further recommendations. The assessment phase supports care pathways to the EYS for more specialist long-term treatment, Adult Mental Health Services or Community Perinatal Mental Health Services.

3.2. Research Question and Aims

Research question: Can the Parent Development Interview (PDI-RF) inform assessment in a CAMHs Parent-Infant Psychotherapy service?

Aims:

- To capture the experiences of the participants who completed the PDI interviews and assess if this informed the parent-infant assessment.
- To find out if including the PDI in assessment could improve clinician understanding of the parent's capacity for reflective functioning and be included in routine assessment.

3.3. Objectives

- To carry out six PDIs and debrief interviews with parents of infants referred to the Early Years Service (EYS) to gain a better understanding of the PDI's potential capacity as a standard routine assessment tool in a CAMHs EYS. Debrief interviews included questions to parents about the PDIs feasibility, acceptability, and length of application.

- An interview with a Psychoanalytic Parent Infant Psychotherapist (PPIP)

completing the parent-infant psychotherapy assessment in the EYS was conducted to capture their views on parents reflective functioning (RF) following the PDIs.

- The semi-structured PDIs are only the first part of the manualised process and must be rated to obtain a measurement of RF. Six PDI ratings were completed to gain a realistic understanding of the time required by EYS clinicians for its inclusion in routine assessment.

The experience, feasibility and acceptability can be defined as:

3.3.1. 'Experience' refers to whether or not:

- the PDI will improve the participant's experience of the assessment; and
- using the PDI supports the decision to continue into therapy or referral to another service.

3.3.2. 'Feasibility' refers to the practical element of the PDI, and whether or not:

- it is acceptable for parents and staff; and
- it can be integrated within the service as a routine outcome measure.

3.3.3. 'Acceptability' includes:

- the length of time required to train staff in using the PDI correctly;
- the time needed by the interviewing psychotherapist for conducting the interview, coding the results; and how useful the results are when interpreted and applied by the clinical team.

I have not reported on the coding data in this study, as I was not researching the

effectiveness of the PDI as a measurement tool. Coding the PDI was a process I wanted to experience to determine if our perception of the parents' RF matched the rating outcome, and this yielded some interesting results discussed in chapter 5.

3.4. Research Design

The research aims to discover whether interviews with parents were feasible and acceptable by exploring their lived experience of the PDI. The research involved six PDI interviews conducted with six participants.

After interviewing the participants, I coded the transcripts and then rated them in accordance with the 2019 manual. As I had not coded since gaining rater reliability, I reacquainted with the manual and immersed myself in the process. Admittedly, it was time-consuming to rate all six transcripts and took, on average, one and a half days each. Once the transcripts were coded using the RF coding table for the PDI provided by the Coding Consortium, I sent 50% (three samples, a high RF sample, a medium RF sample and the complex sample that I coded as low RF) to the second rater for inter-rater reliability (IRR). Despite the small overall sample size to be considered a significant representation, IRR was necessary to ensure I had coded correctly. Apart from the low RF sample, which had to be third-rated by Michelle Sleed, the second-rater and I agreed with the other two samples, indicating my coding was accurate.

The coding results were not used as research data for this study. However, the outcomes informed my colleagues' awareness of each participants' reflective function before conducting the assessment.

After completing the coding, I followed this up with an open-ended qualitative debrief interview about the participants' experience of the PDI semi-structured interview. This would take a maximum of 20 minutes. The total time commitment of participants in both interviews was expected to take at most 105 minutes.

Following the participant debrief interview, I interviewed my colleague, conducting the assessments after giving him the PDI and second rater's ratings. Hence, he had a complete understanding of the outcomes. This data was integral in the research and subject to formal analyses. I have also included my reflections in the findings.

I used the adapted PDI questionnaire sample from the manual (1991) used in the PDI training. This consists of six 'permit' questions. Permit questions are a 'warm-up' in the conversation. They ask how the parent would describe their infant using three adjectives, then ask about their infant's favourite things, what they like and dislike about their infant and what they see as troubling them over the past two weeks. I described the interview to the participants in a conversational tone to put the parents at ease and to give an idea of the type of questions I would ask and reassured them that there were no correct answers.

I then asked the participants' 'demand' questions, in other words, questions that 'probe'. This consists of twenty five questions that refer to the parent's view of their relationship with their infant, their affective experience of parenting, their childhood history, their experience of loss and separation, and a looking back/looking forward section.

This part concludes the interview and helps gather anything the parent wishes to add or feels they want to return to and think more about.

The interview picks up on thoughts and feelings at the moment that may not be fully conscious to the participant. This is likely to encourage a response that aims to increase participants' reflection function.

3.5. Epistemological and ontological stance.

The epistemological underpinning for this study is relevant to the particular population of parents of infants and their experience of the nascent relationship. This is pertinent to the psychoanalytic lens, considering my interest and belief in unconscious communication, transference and countertransference, and the importance of the psychotherapeutic relationship in creating new meaning and understanding. Psychoanalytically informed researchers/authors who have explored the use of the PDI in various settings and participant groups inspire my stance as a researcher. Psychoanalytic concepts inform this field of study in Infant Development, Infant Observation (Bick 1964, 1969) and the intersubjective and transformative qualities of emotional relating (Briggs 1997). Brown's (2006) description of a 'meditative review of analytic work' in psychoanalytic reflexive methods informed my epistemological stance as a researcher. My reflexive position to the research would inform what could be understood by interviewing parents about their relationship with their infant and their experience of the PDI. This informed my hope that by interviewing parents, their capacity for RF would be evident and measurable. I also hoped this method would elicit more data to be analysed and taken further to inform service development.

As Heylighen (1993) states:

> ….knowledge results from a kind of mapping or reflection of external objects, through our sensory organs, possibly aided by different observation instruments, to our brain or mind. Though knowledge has no a priori existence, like in Plato's conception, but has to be developed by observation, it is still absolute, in the sense that any piece of proposed knowledge is supposed to either truly correspond to a part of external reality, or not. In that view, we may in practice never reach complete or absolute knowledge, but such knowledge is somehow conceivable as a limit of ever more precise reflections of reality. http://pespmc1.vub.ac.be/EPISTEMI.html

Knowledge is never static or passive but created through exploration, testing out reality and adapting to new experiences. The epistemological reason for using Thematic Analysis (TA) is to analyse an iterative reflexive process focusing on Psychoanalytic constructs that influence the methodology.

3.6. Researcher or clinician?

In Reflexive TA, the researcher aims to bring subjective and interpretative skills to the process (Braun & Clarke 2021a). As the researcher, I conducted the PDI before my colleague conducted the assessments. During the interview, balancing my role as a researcher with my experience as a clinician was vital in maintaining sensitivity and caution when asking the semi-structured questions. I was aware the PDI could evoke strong feelings during the interview that tap into areas of unresolved internal conflict and vulnerability. I was conscientious about the importance of sensitivity and maintaining warmth and curiosity when prompting the parent, which showed I was actively listening and helped pick up on sensitive areas that needed more containment.

I needed to approach clinically sensitive topics with the utmost care and attention within the ethical parameters of the research study so the participant could engage authentically in the interview. The PDI manual (2019) outlines potential complications

and how to approach common errors in probing too little or too much and explicitly states to keep the clinical voice silent to hear the story the way it is being told. Probes are meant to clarify the story rather than reveal more layers. This was a tricky balance as my clinical voice was ever present if mute, and I was conscious of my urge to explore the participants' responses further. Still, I also had to consider my researcher's stance to 'read' the parent. Countertransference informed my feelings and helped me to adjust my stance to the extent that I would get more developed answers or rich material for coding.

The manual refers to the possibility of the 'halo effect'. This is a positive bias in that parents may give highly reflective answers and can influence the researcher by giving what might be construed as emotional rather than reflective responses. In effect, the 'halo' is a positive or idealised maternal transference to the researcher that could be limiting. For example, I experienced this when interviewing a participant who gave positive responses, but when coding the transcript, her RF was lower than I expected. Had I not been analysing and coding the PDI, I may have had a false impression of this parent's capacity to hold her infant in mind and miss salient information about risk. Alternatively, the participant may give responses that indicate negative and disturbing feelings towards their infant but are conveyed in a reflective manner. I was conscious of this effect and exercised caution not to penalise participants for things not explicitly stated but could potentially cause a negative countertransference response when rating the transcripts for RF. For this reason, it was vital to have an Independent second rater to achieve inter-rater reliability. This also ensures the rater outcomes are credible and robust.

The manual states that responses should be rated purely for mental state language rather than affective content (2019 manual, p21). This is necessary to measure RF rather than the emotional content of the interview. As a clinician, I am interested in the emotional states of mind of the parents to understand their internal world. As a researcher, I had to curtail my clinical interest to focus on the story told in the participants' narrative when they referred to physical or behavioural relational representations rather than descriptions of the affective state of mind in feelings and thoughts.

The parents I met as a researcher rather than a practitioner were able to keep the bounds of this relationship, but it was my task to ensure the same and respond as a researcher. I was wary of refraining from steering the interview or interpreting the content. This helped when I came to reflect on the themes through a reflexive lens to gather what the themes revealed themselves (Braun & Clarke 2021a) rather than try to make meaning. This felt like a very creative, thoughtful process in itself. I was conscious of analysing sensitive material that needed to be handled respectfully.

It was unlikely there would be a wait for an assessment, but in the event of a delay, I planned to provide Counselling service contact details or make a referral to an alternative service. This included the community perinatal service for mothers with mental health needs. I also offered fathers information on services they could access in the short term. I discussed these options with the referrer and my colleague (PPIP) to ensure parents' needs were carefully considered whilst accessing the service.

3.7. Inclusion and Exclusion Table

Inclusion criteria	Parents with mental health problems, including depression, anxiety, addictions, or pre-diagnosed conditions.
	Parents with identified attachment and bonding problems, including those following a traumatic birth.
	Inter-generational issues from the parents' childhood upbringing.
	Parents whose understanding of English enables them to understand the interview questions.
	Parents with childcare options, as it is unsuitable for the infant to be present for the interview. If there were two parents who both wanted to take part in the study, they would each participate separately.
Exclusion Criteria	Parents who do not speak English. This will be part of the study information given to participants.
	No childcare arrangements for the day of the interviews

3.8. Recruitment

The potential participants were parents, mothers or fathers of infants aged 0-5, referred for an assessment to the Parent-Infant Psychotherapy service, and experiencing mental health, relational and bonding problems.

At the referral stage, my CAMHs colleague (PPIP), who introduced the study and invited their participation, approached parents and informed them of the interview.

Parents were given my contact details if they wished to discuss further or to accept the invitation. I then contacted the parents who wanted to participate to provide them with the consent form for signing and to arrange the interview schedule.

When a referral was received in the service, the parent/s were invited to an assessment and to participate in the PDI. If they agreed to participate in the study, parents were informed that they were free to withdraw without giving a reason and that this would not affect the care and treatment/service they receive.

Parents had two weeks to decide on recruitment, their commitment and confidentiality. All parents referred to the PIP service who met the inclusion criteria were invited to interview.

Once the interview had been completed, I sent a letter of thanks (see Appendix 5) and invited participants to the post-interview debrief.

I was involved in seeking consent from participants interested in taking the interview but would not interview any parent-infant couples I worked with clinically. This was to separate the clinical therapy component to avoid cross-contamination or researcher bias.

As it transpired, all the participants were mothers, heterosexual, either married, in a relationship with the father of their child, or single mothers. The mothers' ages ranged from 17 to late thirties. By coincidence, the infants were all sons aged from 3 months to 2.5 years old.

3.9. Ethical considerations

For this study, it was necessary to apply for ethical approval from the training institution where the study took place (see Appendix 6) and the Governance and Ethics Committee for Studies and Evaluations (GESCE) for the NHS Trust where the interviews were conducted (see Appendix 7). I attained local NHS consent from my service supervisor (PPIP) and the CAMHs Senior Management Team, where the research was conducted (Appendix 8). I completed a risk assessment as part of the approval process (see Table Appendix 9).

Ethical considerations are essential as the interview asks personal questions and may trigger an emotional response in participants. This was important to consider as areas of the parent's life could be more concerning and may indicate vulnerable emotions that need careful negotiation as the participant reflects on their answers. For this reason, building a rapport with participants was necessary to support them to feel safe and contained whilst being interviewed and to build a welcoming, non-judgmental milieu. In the 2019 manual, there are clear guidelines that state from the outset to endeavour to put parents at ease. I used a calm, friendly and relaxed tone when describing what to expect from the interview, that I would be asking them about their child, their experience of parenting and their own childhood experiences.

It was important to stay within the bounds of what the participant felt comfortable with and conduct the interview at a pace set by the participant.

3.10. Informed consent

Signed consent from each participant was received (Appendix 10) after each participant was given an information sheet (Appendix 11), which ensured they were fully informed of their consent. It was reiterated that participants could change their minds at any point in the interview and restated there would be no change in what parents and infants could expect from the CAMHs/PIP service, whether or not they agreed to participate in the study and without giving a reason.

3.11. Sample size

I aimed to recruit up to six participants, generating a maximum of nine transcript hours. Considering attrition rates, the sample size was likely to reduce to four participants, achieving 6 hours of transcripts. Parents were informed that it would be preferable to be interviewed without the infant present, which could affect their capacity to participate if no childcare was available.

The small sample size pertains to the length of the PDI semi-structured interview and the amount of data content it could generate. In this student study, I wanted to keep the data to a maximum of 9 hours as I foresaw this would achieve enough data for analysis in this two-stage process.

All identifying details were anonymised. An allocated randomised number system was used to ensure anonymity. It was explained to participants that the small sample group could compromise anonymity. Confidentiality was protected, but direct quotations could be identifiable due to the personal nature of the data. Participants were informed of this before consenting to the research study.

3.12. Data Collection

A) PDI semi-structured interview (Appendix 13). Total time commitment of 90 minutes. This was conducted to capture the participants' capacity for reflective functioning.

B) Participant debrief semi-structured interview (Appendix 12). Total time commitment of up to 30 minutes. This was conducted to capture participants' experience of the PDI.

C) PPIP interview for individual feedback on the outcomes received from the PDI interview by asking four short questions (Appendix 14). Total time commitment of 60 minutes. This was conducted to capture the PPIP insights and experience of the participants' reflective functioning in the assessment.

The interviews were conducted either in person or by video platform, depending on the participants' preference. One parent asked to meet remotely for the PDI interview due to only having childcare in the evening. Other PDIs were conducted in person during working hours. One participant asked to meet remotely for the debrief when concerns about a new coronavirus variant increased the need for social distancing.

D) Written field notes: used to record researcher experiences throughout the research process. This helped to capture unconscious transference and counter-transference material emanating from the participants' responses.

The semi-structured interview, brief interview and PPIP interview were audio-

recorded, transcribed and rated using the manualised coding system (Aber et al. 1985). I have been trained to rate the transcripts and received (accreditation for?) rater reliability (Appendix 4).

Routine clinical data was collected at the referral stage by the referrer and entered into the recording system by administration staff. Routine clinical data consists of name, date of birth, NHS number, address, GP details, and contact details.

3.13. Qualitative Research/Thematic Analysis

Reflexive Thematic Analysis (TA) is a theoretically flexible approach compatible with psychotherapy research, which is suitable for this study (Braun & Clarke 2021a 2021b). Using a reflexive stance, I was an active resource in the study through my subjective experience. Braun & Clarke (2021a) elaborate on the position of theory and research in reflexive TA as a lens through which data is analysed and interpreted (p4) and that the coding process is integral to theme development.

By reading, reflecting, pondering, questioning and writing, I could harness some thoughts about the themes and form some ideas about their latent meaning, not just in terms of the unconscious but also what could be captured in the themes beyond the surface. This new stance as a researcher enabled me to consider the data as the 'thing in itself' (Bion 1990) rather than a step toward something else.

According to Rustin & Rustin (2019), qualitative analysis in social sciences is the starting point for psychoanalytically orientated qualitative research. Thematic analysis

is a variant of grounded theory used in analysing social action and human experience (McLeod 2011). McLeod (2011) states TA is the most flexible, straightforward and accessible method applied to psychotherapy (p146). Given the reflexive stance and semi-structured interviews, this seemed the most relevant data analysis for this study (Joffe 2012, p4).

Quantitative research into using the PDI manualised tool (2019) is prolific in measuring maternal reflective functioning, e.g. the predictive correlation between infants' attachment style and mothers' capacity for reflective function (Slade et al. 2005a). This form of coding is qualitative (2019 manual, p29) in that specific parameters for arriving at an overall rating cannot be described but become refined with the systematic rating process.

In analysing the data from the post-interview questions using TA, I identified patterns by using themes guided by the inductive content of the data and, therefore, data-driven (Braun & Clarke 2006) within the epistemological framework of psychotherapy.
Collating and reviewing the main themes and broader patterns can enhance the realistic and descriptive account of the practitioner and participant experience (Braun & Clarke 2006).

The data sets gathered from the themes were from participants' responses to the debrief interview. There could be a collaboration between researcher and participant, further supported by engaging with the literature early in the inductive process before interviews were conducted. At that time, I was unsure how this would influence my literature analysis, but I found it helpful to map the relevant research and theory. I

could read and re-read using a recursive process (Braun & Clarke 2006) rather than linear, moving back and forth between the different stages. As I immersed myself, I became familiar with the data. Another important aspect of TA is that I repeatedly listened to the audio recordings as I read the transcripts to ensure I had captured an accurate account of the interviews.

TA is relevant to this study given the context of rich material and theoretical freedom (Braun & Clarke 2019). A combination of the PDI coding exercise and TA enabled a deeper data analysis of the interview outcomes beyond the rating. This provided two distinct but complementary qualitative methods that overlap with psychoanalytic thinking to draw out inductive themes from the semi-structured interview. This method lends itself to TA as latent content starts by identifying underlying ideas key to interpreting themes 'without sacrificing the depth of analysis' (Joffe 2012, p2) beyond description by creating a 'story' of the analysis. The themes gathered informed the experience of conducting the interviews. By developing meaningful patterns through coding themes (Braun & Clarke 2006), I aimed to capture a deeper understanding of the parent experience and my colleague's experience from the assessment.

Chapter 4 Findings

In this chapter, I will discuss my findings from the analysis of the debriefing interview. I have divided this into themes revealed from the thematic analysis through an inductive process, where the data determines the superordinate and subordinate themes, and reviewed the latent themes underlying the data.

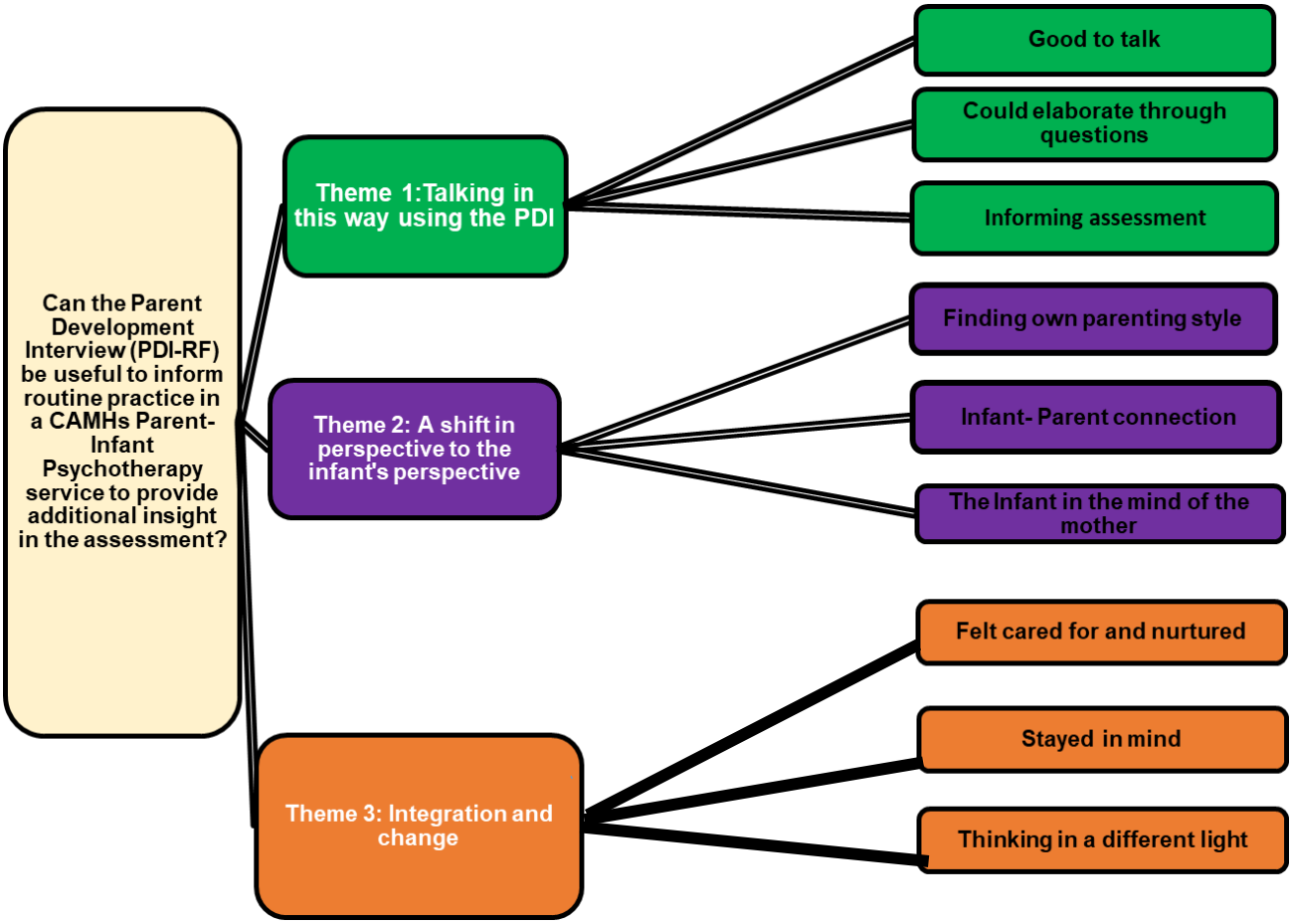
As the researcher, I actively identified the patterns that formed the themes (Braun & Clarke 2021b). For this reason, I have included extracts from my field notes to capture something of my subjective experience in conducting the interviews as a reflexive process (Braun & Clarke 2021a) and to illustrate themes with participants' responses to the four questions.

Using Thematic Analysis (Braun & Clarke 2021b), I found three main themes from the data and three sub-themes in each, as illustrated in the table below:

- Talking in this way using the PDI

- A shift in perspective to the infant's perspective

- Integration and Change



Thematic map. [Fig 1]

Initially, I explored each question in turn to find salient themes. I found analysing in this way reductive and did not capture the participant's interview experience so thoroughly. I was more curious about their experiences and my own rather than looking for answers to the questions. I used the questions as a vehicle to stimulate conversational material about their experience of the PDI interview, whether or not this facilitated their assessment, and how they felt after the first interview to ascertain any adverse reactions or insights.

From the coding process, I was aware of each participant's capacity for reflective functioning, ranging from low, low to moderate and, in one sample, moderate to high.

This also helped when compared with the debrief transcripts. I found more rich data by holding the participant in mind and reflecting on their diverse responses, providing a relational subjective interaction that captured something of their experience. This approach opened up themes relevant to each participant and their reflections on their subjective experience.

4.1. Main themes

Theme 1. 'Talking in this way using the PDI' (see Table 1/Appendix 1).

This theme refers to the participant's responses to the length of time it took to conduct the PDI and if the questions were understandable. From their responses, all the participants were unanimous that the length of time was not a prohibitive factor, '*Yeah, I don't think it was rushed I think it was, it was a fine amount of time (001: 8-9) and 'I didn't think it was a burden or anything…* (001: 153), and *'It was just right. It wasn't too long. It wasn't too short.* (004:6). Another participant said she *'thought it was perfect to be to honest. Yeah. And it felt just right'. (005:7).*

This theme developed from the participants' responses: '*I think I think at the time, it was probably about right. It didn't feel like a long time, for me, no, it was perfect length. I think'* (006: 8-10) and reiterated by the same participant who thought '*it was long enough that you could go into a decent amount of depth on the topics. It wasn't long, long enough to be gruelling. I don't think it was overwhelmingly long. I think there was enough time to cover everything in detail* (006:15-17).

When asked if the questions in the PDI were understandable one response was '*Yeah, definitely. They're very clear and right to the point and understood. And it just,*

it was actually quite easy and quite nice to do that'. (005:83-84).

This theme suggests the importance of feeling unpressurised and having enough time to answer the questions. It also overlapped with 'good to talk/could elaborate', suggesting participants could ponder their reflections and have time to explore their thoughts openly and honestly. This illustrated how participants found the experience gave them a sense of what therapy might be like, for example: *'I think it was very therapeutic. Really, it felt like a like a chat, even though it had a clear structure'*. (006:67), and *'it felt a bit like an intense therapy session'*. (001:40). There were comments about the progress made: *'yeah like I feel like, made me feel like, how far I've come. So yeah, like it was good to reflect, so it was quite good to reflect and stuff, how much has changed'.* (001: 62-63). This participant reflected on improvements in her relationship with her infant: '*So yeah, obviously* we're*, we've got a lot better bond and stuff now so that's what I was always worried about'*. (001:65-66), and noticing they had time to think and look back over time: '*it was good to reflect as such because I've don't really think like hadn't really gone over anything from the beginning'*. (001:63-64).

How the questions were asked brought up themes of 'feeling looked after' and 'cared for'. Participants noted a break was offered, and consideration was given to their needs. For example: *'yeah I think you gave me the time to speak and you know you made sure that I was okay and whatever else and you know you offered the break if I needed it and so yeah'*, (001:8-9).

The latent content of the theme suggests the importance of paying attention to their comfort, further illustrated here: '*So I think for me, it was good. I wouldn't have asked for more questions, but and the ability to have a break when I wanted, it was good'* (003:33-34). Another participant said, *'we had that time to have a drink and stuff which is just enough. Time to just kind of take a breath for a minute and just kind of get back to what I needed to do'* (002:10-12).

In answer to the same question, one participant thought about how the questions were asked and considered how others may feel in her response: '*I don't tend to feel threatened by that anyway, I suppose people could, but I don't think your manner was threatening if that makes sense. So I think that I do think in general that it's definitely a positive thing'.* (006:74-76). The same participant recognised important aspects of the interviewer's manner when answering: '*Yeah, I think it definitely did, because I think I think it is definitely important. If you have an interview with an interviewer to be personable. I think you definitely were. So I think it felt like a non-threatening environment. It felt accepting, if that makes sense. I didn't feel like I couldn't say things'*. (006:79- 81). This suggests the interviewer's openness enabled an open response from the interviewee. This 'setting the scene' and the pace adds to the attention to detail needed to give participants an authentic experience where the interviewer guides and is guided by the responses.

4.2. Sub-theme: Good to talk/could elaborate through questions

Responses to the PDI in the debrief interview suggest that participants felt they had a preliminary experience of what it might be like to be in therapy, described by one participant as 'like therapy but not therapy', which overlapped with the previous sub-

theme—being asked how they felt led to creating a 'positive reflective space' and 'freeing up discussion'. For the more reflective participants, the interview stayed in their minds and enabled them to reflect on their responses. For example: *'I think the questions were okay I think they were relevant. I think you sort of need that, you know, to discuss that to get to the point of how it affects you. Now being a parent. So, I think the questions are good to keep them in there. I guess it's just upsetting because you know it's not dealt with at the moment* (001: 82-87).

For the less reflective, they found it did not stay in mind or reveal further thoughts. An overall trend showed that participants could see a link or pattern in the questions about issues they were familiar with. The questions were directly related to personal experience and felt pertinent and relevant*. 'I did think it was helpful. I think like, everything about it was good. And like just I just really liked the experience and its like, questions nobody ask', like, once you start conversation with me about like, baby, my feelings and my family. I like to just like blurt it all out. And it's like it's just really nice. But don't get to do that a lot'*. (005:136-139).

The latent content showed a progression in the themes and how the questions enabled participants to consider what may have caused their underlying difficulties, as in this example '*It was good and it makes.. it made me maybe look into more emotional side of things that maybe I never would have before and I think for me, that's quite that that never really happened to me before. So whether it was the way stuff was questioned, or maybe it was ..it made me think more.*.(003:30-33). This participant thought about the pace and type of questions asked*: 'I think kind of the amount of questions that was there was a good amount of time to get through that but not feel rushed. I was able to*

kind of elaborate on stuff that I wanted to talk about, and it made me think about things in a different light to how I would every day' (003:36-38). For mothers with very young infants, there was a struggle to consider what the baby may have been thinking '*Some of the questions that were asked I thought, like they some of them might have been a bit young for (baby), but there's certain questions about.. I can't remember the exact questions, but like, I felt like he was a bit too young for me to be answering them because it's like, he's not that developed'* (005:9- 12). This was also evident with a mother who had not previously considered her infant's feelings: *'the only bit that I weren't really answerable was like the well how'd you think it makes him feel? That because obviously, I hadn't really thought about how it makes him feel. But like, it's also important to have them questions actually make us start seeing it that way'* (002:87-80).

The relevance of the questions to their parenting role and relationship with their infant was evident. The notion of having space to reflect before the assessment revealed in the 'good to talk/could elaborate on the questions' was considered to be a valuable experience. '*No, I really like the questions ..that just opened up so much. I just think about it all the time'* (005:99).

Whilst themes do not indicate an overall trend, differences in the impact of the interview indicate where some participants held in mind and reflected on their responses, but for others, this was not the case, nor did it inspire further thought.

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4.3. Sub-theme: 'Informing the assessment'.

Responses varied to the question of whether participants thought the PDI would

support or inform the assessment. All participants thought the 'right time' to conduct the interview would be in the assessment to explore more about the parent's experiences 'in a helpful way'.

Sub-themes such as 'thinking together' and 'opening up the conversation' suggest something is felt to make the assessment more accessible and the reflective process more available in the participant's mind. The PDI could be understood to set the tone of the assessment and may reduce anxiety for parents seeking support without previous experience with mental health services: '*I think it made me open up a different emotion that maybe I've shut out for a long time. So, I was able to recognise that I felt vulnerable in that area. I could then say that out loud. What whereas before maybe I hadn't even questioned that or thought about that'* (003:25-27).

The notion of 'thinking together' brings into focus a relationship with the PPIP as a curious and interested partner. '*Yeah. Yeah. It just felt more like a good conversation'* (004: 48).

The 'good to talk' sub-theme, whereby the notion of 'like therapy but not therapy' and a 'positive reflective space' where discussion is 'freed up', indicates that the questions from the PDI were understandable, pertinent and relevant. The questions seemed to stimulate insights and could inform how parents engage in the assessment. For instance, *'I think the ones to do with my relationship with my family. And them ones I thought like they were very relevant'* (005.19-20).

Several participants wondered how the assessment would help their emotional and parental relationship progress. Still, given it was 'early days', the PDI helped them consider what the work would focus on and help them to start to think, as thinking did not come naturally to all participants. Beginning to think about what hadn't been thought about before is highlighted in this comment: *'thinking until when we did the interview, I'd really not thought that much about how my experiences will shape the relationship to come. Sort of things like how my guilt over my parenting might affect how (child) feels. And I think it's something like I'll definitely bear in mind going forward. So haven't really put enough thought into that until then*' (006:25-28). This was also evident here: '*I think that there definitely were some thoughts that hadn't really come to the fore until then. So I can discuss my feelings of guilt with (therapist) for instance, because that's something that I definitely took away from that that my guilt is actually something that's quite important to discuss'* (006:53-55).

This theme encapsulated the idea that it would be best to conduct the PDI sooner rather than later in the process. Participants perceived that the assessment would be different and improved by conducting the PDI and would help the therapist with what needs to be thought about by having more information during the assessment phase.

4.4. Theme 2. 'A shift to the infant's perspective' (see Table 2/Appendix 2).

From the central theme, it was possible that the infant's experience had not been at the forefront of some parents' minds. This theme suggests new realisations and insights occurred during the interview on the past, present and future developmental impact on the dyadic relationship. Themes also show how the interview questions brought about a more integrated view of parenting that enlightened a sense of change

and progression. Links were made between the parents' upbringing and how they were parenting their infant. One participant said, '*And that kind of made me like look at my parents in a different perspective, or like fresh eyes in a way because like it opened up a lot … like you're thinking about it and thinking about all the little things that you like, didn't really like- just things that are in the back of your conscience in a way that like just like come up with Oh, I never thought about it that way before. I forgot about that'* (005:30- 34), and '*Just talking about different things that happened, like, like things will happen with me and my mum. And then it's like, small little snippets in like history, like from how she parented me, and I thought, yeah, I definitely wouldn't do that and things'* (005:36-39).

This seemed to signify a new awareness and a desire not to repeat bad experiences or to be able to make use of good experiences. Learning from experience and thinking rather than acting seemed a prevalent theme with aspirations of being a 'better' parent. One participant said, *'I want to be very different from my parents'* (003:73). In contrast, another participant said,' *that was about how I strive to be a better parent and like, what my mother and how to tolerate she's been through hard times and how much I've kind of taken on that as well'* (004:50-51).

This appears to connect with the participant's reflections on the effects of trauma through intergenerational patterns of behaviour and the desire to prevent repeating the cycle. On a positive note, participants acknowledged in hindsight that they had learnt from their parents, whether it was what not to repeat or what was beneficial from their upbringing.

In the literature, early research indicates Low RF discerns the parent's limited awareness of their unconscious. *'I know it sounds bad, but I've never really considered how it made him feel'* (002.24). Therefore, measuring RF may support the parent to develop more understanding of their unconscious states of mind that impact their relationship with their infant, '*the only bit that I weren't really answerable was like the well how'd you think it makes him feel? That because obviously, I hadn't really thought about how it makes him feel. But like, it's also important to have them questions actually make us start seeing it that way'* (002. 81-84).

4.5. Theme 3. Integration and change (see Table 3/Appendix 3).

This theme seemed to resonate with parents' thoughts about their infants and their capacity to parent and connect meaningfully with their infants. This seemed an enlightening aspect of the sub-theme 'Infant-parent connection'. This theme highlighted some reflections on the role of the father in the mind of the mother and the role of a father for infants, which may relate to all the infants being male. This resonated with the question about 'being like/not like your father'. Having first met the (male) therapist may have instigated a paternal transference.

It was apparent that the father's role was held in mind as an absent figure. *'Yeah.Yeah, it's like I worry how much that's kind of putting on him because I've known right right from the start, that he's got a problem with being around males because obviously we're not apart from my dad, brother. There's no one else really about …I suppose it is like a big deal that obviously we are seeing (therapist-male)… we've had conversations about it and yeah, ….and genuinely wants to help whereas like, most men in my life, aren't like that. So yeah, we've it has been a huge conversation that*

we've had' (002. 93-104).

However, in the interviews, fathers were considered in relation to the infant's development. This also seemed to evoke the role of the parental couple in the therapy and everyday life of single mothers. Fathers seemed to be internalised in the minds of partnered mothers who considered the father's upbringing as an influence on his capacity to parent and his parenting style. 'It's *like (baby's father) will be like the new me well baby will be the new me. Just trying to even out and make sure that we do everything the way we want to and like not to let the past affect us because I'll have trauma from the way my parents parented me. And I know they have trauma because my dad's got attachment issues. And he's got because his dad abandoned him'* (005. 195-199).

This resonated with the participants' thoughts about how both parents could influence their sons. '*definitely things that I didn't realise until I actually spoke about that was I don't usually talk much about what my dad come through as a child and how much that affects my parenthood. And how much of it motivates me to be a better mother to (son)'* (004:50-52).

Being different from their parents brought out thoughts about the participants' upbringing and what they would do differently in raising their sons. The participants could recognise patterns through the PDI questions, suggesting a capacity to reflect on their internalised infant self and how they were affected as children.

These themes related to the mother's experience of the interview, how the researcher asked the questions and the questions asked. One participant said, '*I think, because I knew what to expect it didn't feel strange or anything like that. It felt quite natural. It felt as if you were prompting me to continue on certain topics as opposed to as I say, probing I suppose some people could feel that way but for me, it definitely didn't feel like I it felt like a natural progression to discuss certain topics'* (006:45-48).

The 'Feeling cared for and nurtured' theme continually repeated and overlapped with the 'good to talk' theme. Asking questions about participants' relationships with their infants and parents stimulated new awareness and the capacity to think about their emotional states. '*I was able to kind of elaborate on stuff that I wanted to talk about, and it made me think about things in a different light to how I would every day' (003:37-38)*.

One participant spoke about never having thought before or being asked whether she felt she needed looking after. This participant reflected on how this question stuck in her mind and helped her open up a different emotion that she had shut out for a long time. She spoke of recognising that she felt vulnerable in that area.

'*Yeah, I think I put in my mind up things that I hadn't thought about. There was a question about can't remember exactly how it was worded but something about who cares for me? Do I ever feel like do I ever feel like I..need looking after...? Yeah, and that kind of stuck in my head. I think it made me open up a different emotion that maybe I've shut out for a long time. So I was able to recognise that I felt vulnerable in that area. I could then say that out loud. What whereas before maybe I hadn't even questioned that or thought about that'* (003. 21-22, 26-28).

In response to the question on change, one participant said, *'it makes you sit and realise. Like sometimes when you've been through a lot yourself how much it can change you to be better. But it's not the case for everyone'*. (004:59-60). Another participant said *'I think the biggest thing that kind of really stuck with me from the interview was like, if you can go back in time, like, what would you change? That was like the real big kind of sticking point for me because obviously, there's so much I would change, like from so many different elements really like…*' (002:50-53).

These excerpts illustrate the effect of specific questions asked that stimulated new thinking and opened up deeply buried emotions, for example: '*It made me maybe look into the more emotional side of things that maybe I never would have before and I think for me, that's quite that that never really happened to me before. So whether it was the way stuff was questioned, or maybe it was ..it made me think more. So I think for me, it was good*.…' (003:30- 34).

This resonated with themes concerning what 'stayed in mind' and sparked something not previously noticed. '*Yeah, I didn't think about it a lot that night, it opened up for me to think about that I've never really like sat there and pondered about ...so it was quite interesting and erm..just like to think into the future about like…and how I want to like parent in a way to like from his point of view, what's best for him, made me think about that'* (005:24-28).

Some participants recognised thinking more after the debrief interview when they met with the therapist during their assessment when it came back to mind. '*Yeah, definitely. It's like opened up new subjects to talk about because I don't know I got nervous*

coming here because I didn't know what to talk about. And things like that because it's mainly to do with baby' (005:95-97).

This theme showed the impact of the questions asked were key to what thoughts became accessible and thought about in 'a different light', suggesting something new could be thought about or become more integrated into the participants' minds during the interview. *'I didn't realise it'd be so helpful and open my mind to so much thing' (sic)* (006:83).

These responses could be identified as areas needing attention in the assessment or to inform ongoing therapy work. Participant responses to the questions showed low divergence in their experiences of the PDI that resonated with each other's experiences. Some mothers interviewed had strong emotional responses to the PDI said it was helpful but also tricky. Much of the feedback was positive, and, on reflection, the set-up and my role as a woman with all-female participants could have been facilitating factors influencing their answers.

4.6. Environmental factors

All the participants had previously experienced the environment where the interviews were conducted, which may have been a containing factor in their familiarity with the setting. All the mothers had male babies, which may have been a factor in their willingness to engage in that there may have been a positive identification with a male psychotherapist and a desire to please. This may have created a positive bias in the research, but rather than an impediment, it seemed that mothers felt there was an opportunity to be looked after and to share their parenting role in identification with a

'parental couple'. I am not implying these were conscious considerations but reflections from the outcomes of the analysis.

4.7. Reflexive process.

I have included extracts from my field notes to capture something of my subjective experience conducting the interviews as a reflexive process (Braun & Clarke 2021a). Before conducting the debrief interview, I was conscious of holding my experience of the participants' emotional experience of the PDI and my experience of coding and rating the PDI transcripts in accordance with the manual. I considered what I was carrying into the debriefing interview from the PDI semi-structured interview. I knew this would influence my data analysis in a reflexive context, notably of a relationship between the participants and the researcher during the PDI. The reflexive stance supported my capacity to interview the participants and respond openly and authentically to the profoundly personal nature of the data gathered.

My reflective functioning and capacity to receive the participants' responses in a non-judgemental, open stance were necessary for trust to form and enable participants to answer authentically and openly. The following excerpts from my field notes illustrate my experiences. In addition, what I held from the material embedded in the interviews.

'*It struck me in some of the interviews, the depth of maternal hostility and hatred a mother can feel towards her infant. These emotions had surfaced in other interviews but to a lesser degree. It was evident their feelings of self-loathing were being directed towards the self and their infants, possibly as part objects, in that they saw a representation of their internal self-hatred mirrored in their infant and responded with their experiences of how they felt towards themselves. It seemed that they struggled*

to find any goodness they could pass on to their infant and to see the infant as more than a physical manifestation of their internal beliefs, even self-disgust. As if the infant becomes evidence of the mother's self-identification'. (Researcher field note 1). I noticed it felt very uncomfortable and painful being party to these openly hostile emotions, and it makes sense of the need for the parent to be interviewed without her infant present, '*it also felt important to support the parent to recover some goodness in themselves and their infant. They seemed to find the questions enabled them to discover feelings of warmth, caring and goodness in themselves, and more compassion towards their infant, a dawning that their infant is a person in his own right and not an extension of themselves*. (Researcher field note 2). '*The disappointment that the parent didn't have what they held in fantasy was palpable. The questions enabled them to think about the positives, be more compassionate towards themselves, and connect their upbringing with their reality as a new parent'.* (Researcher field note 3).

I learned more about the participants from their responses to the PDI questions and the personal information they shared by studying the transcript. My countertransference sometimes resonated with the mother's emotional experience of sadness, anger and desperation. In other cases, participants actively tried to understand the infant's perspective and the impact of their relationship on their infant's future development. In all cases, I was inspired by the mothers' courage and eagerness to learn more about themselves as parents. '*When I worked on the transcript, I was impressed with the depth of material participants brought to the interview and the level of intimacy. I could see how much they were working through their past and relating it so thoughtfully to the present relationship with their child.*

There seemed to be some recognition of their progress in their recovery. I could feel their sadness and the suffering they endured. I was very moved by the participants' commitment to the research and willingness to be open and honest, and I wondered what influenced this'. (Researcher field note 4) '*I realised from conducting the first interviews that there needs to be time between conducting and transcribing the PDI and then coding. Chiefly because the interview can be compelling and needs some distance to 'read' and experience the narrative with fresh eyes and an objective lens to maintain the researcher stance. I felt drawn into the stories, which affected my countertransference as a clinician immersed in the responses. It felt necessary to experience the participant's affect and emotions for the interview to feel authentic.* (Researcher field note 5).

The impact of conducting the PDI, whether in person or on a remote platform, was equally emotional. I had no control over the environment online and found it harder to 'measure' ostensive queues or 'read' the atmosphere. This was particularly so with one participant who asked to interview in the evening and then had a long delay before we could conduct the debriefing interview. I sensed this was not putting a burden on this participant, and in fact, the debrief interview seemed to help us learn something together from her experiences. I would say interviewing at 7-9 p.m. was intense after a day's work. I recommend that the interview be conducted when both researcher and participant have the energy, stamina, time and mental space due to the intensity. *'I would have felt more reassured if she had replied to my text and felt I was holding her anxieties conveyed through her silence. I wanted to respect her need to recover from the interview'* (Researcher field note 6).

In another interview, the participant sobbed gently but wanted to reassure me that she was “fine”. She linked her sadness to things she described as ‘undealt with’, but I was conscious her responses might impact her assessment. ‘*I could see the transference relationship might not have been helpful for her therapy, noting some splitting, that I had become the helpful one and her therapist the one who made her feel awkward – the one she saw as not giving her what she wanted, as if I had become her therapist. I knew this had to be handled delicately to enable her to continue the PIP work to support her relationship with her son and her mental health’ (Researcher field note 7).*

I also had some anxieties about the participant who wept throughout the interview. In my notes, I wrote, *‘Although her tearfulness increased at times, she could continue and remain intact and engaged in the process. I felt this was a powerful experience for me, but held within the boundaries of what she felt comfortable sharing* (Researcher field note 8). I checked in with her to see if she was willing to continue and was reassured that she was, but she did acknowledge it was bringing up complex thoughts and feelings from her experiences of motherhood*. ‘I was reassured by my colleague who had met with the participant and her son for an appointment after the interview. She said although she did find it hard, she was alright. He acknowledged that initially, he wasn’t sure how she would cope, if it would be too much, or if she was suitable’ (Researcher field note 9).*

I told my colleague she wants therapy to work on her past traumas. I tried to prevent disrupting my colleague’s work, knowing it would benefit her’. (Researcher field note 10).

My reflexive process enabled my own reflective functioning during the interviews to

deepen my experience and thinking function in the TA, conscious of the potential impact on the assessment. For this reason, it would be important to interview my colleague conducting the assessments after completing the debrief interviews.

4.8. Colleague interview

Using a semi-structured interview (Appendix 14), I analysed how the PDI contributed to the assessment process from my colleague's perspective and his reflections on the participant's assessment experience after completing the PDI. This interview took 45 minutes and was captured on a remote access platform using the audio-recorded transcript software.

We reflected on themes about the experience, feasibility and acceptability of the PDI. I have summarised below our debrief conversation and specific points raised when we reflected together as researcher and therapist conducting the assessments.

4.8a. Experience

My colleague thought conducting the interviews when participants were in a phase of positive transference could have influenced their responses. It is important to enable trust to form in the developing alliance between therapist and parent. Likewise, it was necessary for trust between participant and researcher to form for the experience to be meaningful.

From the debrief interview, we agreed that the PDI gives a depth of thinking about the relationship that may not otherwise be arrived at and a deeper emotional response from parents. The PDI seemed to provide mothers with a preliminary insight into their

experiences.

In one example discussed, a participant in the early stage of her assessment was helped to focus more on the relationship and why things are so difficult between herself and her infant son. In the follow-up debrief, it was possible to experience this mother beginning to see how her relationship with her infant mattered. This was something this mother had not considered before, but after the PDI and the assessment, it was possible to see a progression in RF during the follow-up debrief.

4.8b. Feasibility

A question about pace and timing, whether to take up something in the assessment or wait for it to emerge from the parent, was considered by my colleague, who noted that as an assessment tool, the PDI does speed up openness and awareness. This was a positive outcome as assessments rightly ask people difficult questions and evoke difficult feelings. It can also be a disadvantage if too much is opened too soon.

In answer to the question about how participants thought the PDI at the assessment stage it helped them understand more about their parenting experiences. It seemed that participants experienced the PDI to be something that would help as part of an assessment for therapy.

My colleague noted how only one participant could think about how her responses might have affected the therapist or others and how other people might experience the interview. This suggests she could project an idea of how others might be affected by using her own experience. This conveyed a realisation that others, as does her infant,

have thoughts and feelings. In the PDI coding, this would be rated as moderately high reflective functioning, as she could mentalise another person's mind.

As an outcome, the participant's responses showed that the PDI has the potential to measure the parent's capacity for RF and could support decisions about what kind of intervention would be helpful and whether or not an intervention, including psychotherapy, is helpful. My colleague noted there is potentially some substance to the suggestion that psychotherapy may or may not be indicated from the outcome of the PDI.

4.8c. Acceptability

The measures tallied with our impressions of the parents from the PDI-RF coding and assessments. There was a very clear correlation between questions the PDI asks and what matters to people. '*In many ways, the interview helped to carry the interviewee through the difficult questions in quite a clever way, and there is always countertransference that protects the interviewer from too much anxiety'* (Colleague quote 1).

The time between conducting the PDI and then the debrief interviews seemed a significant factor in giving participants time to think and, in some cases, not think. The participants notably reflected on what came into their minds consciously and unconsciously during the debrief interviews and assessments. If the PDI is helping to set the foundation of therapeutic work, the question of whether or when to conduct the PDI could help us think about when best to apply, what the work will be about and potentially highlight the preventative work needed. This tool may have a lot of value to the ongoing therapy. If a follow-up interview was conducted, this could indicate if RF

had improved by engaging in the intervention offered or after the intervention had been completed.

The PDI is psychoanalytically informed and does strongly underline talking therapy. Often, parents come in and think they are going to get advice. Instead, it is explained that PIP is about the relationship, thinking about their child, and noticing. '*The interesting thing about passivity and inactivity in an interview is that it finds a certain amount of passivity in the interviewee. That differs from actual therapy, where the parent is encouraged to be more active. It was helpful to experience the opportunities the PDI offers and a chance to have a measure of reflective function that is accurate. The PDI is a strong contender as an assessment tool. The difficulty is that it is not a quick implementation, but it is probably one of the richest assessment tools.* (Colleague quote 2).

4.9 Researcher experience as PDI interviewer and rater.

In this section, I reflect on my experience conducting the PDI as a professional in the service and my perspective as the PDI interviewer and rater. I will evaluate the feasibility and acceptability of performing these two roles simultaneously.

4.9a Experience

I was conscious that conducting the PDI and the debrief interview may have set up a transference relationship that could have biased participants' responses. I was aware this had implications for the data analysis in that participants may have provided positive responses due to the transference and wanting to impress the researcher or therapist.

I also wonder if the same person conducting both interviews may have had more influence than I expected or could have controlled.

The set-up had been considered very thoughtfully. My colleague, the PPIP conducting the assessments, was the first person the mothers met and who invited them to participate in the research. Their experience of the welcome to the service from my colleague could have influenced their decision to participate. I reflected on how meeting a male therapist in the assessment and then a female researcher might have promoted a transference of a 'parental couple' in their minds. I wondered if this might have been a containing factor. *'I reflected on the importance of sensitivity and felt I conducted myself sensitively throughout. It was powerful for the participants and me, and we seemed to be taking care of each other by checking in to see if participants could continue or needed a moment and then letting me know they could continue. I was worried about the effect of participating in the PDI*' (Researcher field note 11).*' It showed me how important it is for the participant to be in assessment or therapy to reflect upon their experiences from the interview and memories from the past brought back to mind connected to trauma. I also felt I needed to hold on to the positives, their available resources that showed strength and resilience evident in their relationship with their child'* (Researcher field note 12).

The interview questions must be asked sensitively while attending to the participant's relationship to the service, their infant, and the interviewer. If the more challenging questions felt too probing, the interviewer's manner could act as an emotional buffer so the participant's and interviewer's defences remain intact. This is why training to use the PDI is required. It also helps to have the experience of the infant observation training that hones observational skills.

This differs from routine outcome measures, which any clinical team member can conduct without training and prior knowledge of the patient.

The PDI left some participants in a more vulnerable place. I was aware that they needed to feel contained and safe to answer the questions honestly and openly. '*I was amazed by one participant's answers, which were generous and authentic; she seemed able to make links between her childhood and her hopes for her relationship with her son and her desire to protect him from her distress. She considered her son's needs and how she tried to take care of herself to take care of him. She was aware of the intergenerational impact of her experience of parenting. Her story had form and shape, and I could follow the details of her past and needed little clarification to follow her retelling. She gave a vivid picture of her experiences, which enabled me to build a sense of her emotional life. This felt positive in that I could stay in the role as a researcher and not be pulled into a therapy role. My stance was caring and interested, and I strongly empathised with her'* (Researcher field note 13).

Questions opened up for me about a more fragile participant's needs when conducting the PDI and what skills are required of the interviewer. Another point is that it is not just parents struggling with RF. It should not be taken as a given that all practitioners have the capacity for reflective functioning or can discern that infant distress and anxiety can cause mental health difficulties, which PPIP practitioners must carry.

In my experience of conducting the PDI interviews, I instinctively took up a warm, nurturing stance. When I interviewed the participants for the debrief, I noticed they

responded with the same reciprocal warmth and familiarity. This benefitted the process, evident in the data sets, but perhaps more importantly, it was apparent something was internalised from the experience of the PDI interview.

I was grateful for the participants' time and dedication in answering the questions thoroughly and honestly. Participants were open and willing to think about their answers reflectively. '*I felt drawn into the sadness of their stories; it was hard to hear the trauma and pain of their experiences with their infants. I felt absorbed and immersed as the stories unfolded, and I admired the mothers' strength and the journey they have been on'*. (Researcher field note 14).

This may not have happened if participants felt threatened by the questions.

4.9b Feasibility

I considered whether or not the semi-structured interview was feasible as an intervention in its own right. I believe that the roles of researcher and therapist are distinct yet complementary. Clinical judgement is critical to assume both roles simultaneously and effectively. My researcher role was informed by being a therapist. I was aware I was holding the participant's experience.

According to the 2019 manual, interviewers are not expected to be objective. This means that the subjective experience of the interviewer is important to note and contributes a richness of data that would otherwise have been lost to the process.

CAMHs must be involved with the EYS age group; otherwise, this work could be held with staff who may need to notice the risks but lack experience.

The manual advises how the subjective experience is key to rating the transcripts. The interviewing experience aided my role as a rater and gave compelling evidence of potential risks to the infant. The PDI rating picked up points of trauma, which could support the assessment when RF seems absent or heightened by anxiety.

3.9c Acceptability

To return to Braun & Clarke (2021a), the researcher actively identifies the patterns that form themes. I was undoubtedly active in identifying patterns and themes and interviewing and rating. This felt like a collaborative experience where the themes were co-constructed between participants and the researcher.

Some participants expressed more availability and open reflectiveness towards their infants. The symbolic scaffolding parents need when a baby is born was akin to the PDI questions, which provided a symbolic scaffolding for the interview. Participants' openness may have indicated the importance of the structure provided in the sequence of the questions. I, too, found coding the transcripts acted as a form of scaffolding around my thinking whereby I could hold in mind the participants' responses in more depth. It felt acceptable and authentic to have formed a relationship with the participants as an interviewer before coding. The participants expected the information to be shared with their therapist, as we had explained in their consent information. Participants found this reassuring and acceptable.

4.10. A question of guilt

One surprise was the omission of asking the question that focuses on guilt in two interview samples and felt relevant to the findings.

From my field notes, I observed that the PDI builds up trust and openness, a total transference (Joseph 1989), so to speak ‘In ‘Transference: the total situation (1989), Joseph describes how the total transference must be everything brought into the therapeutic relationship by the patient.

As Joseph states:

> Much of our understanding of the transference comes through our understanding of how our patients act on us to feel things for many varied reasons, how they try to draw us into their defensive systems, how they unconsciously act out with us in the transference, trying to get us to act out with them; how they convey aspects of their inner world built up from infancy — elaborated in childhood and adulthood, experiences often beyond the use of words, which we can often only capture through the feelings aroused in us, through our countertransference, used in the broad sense of the word. (1989 p157)

The total situation has to be considered when interviewing participants for the reasons Joseph describes, in that transference supports our understanding of the feelings and defences of the person we are working with, imbued in childhood and adulthood experiences. Equally important are the experiences not conveyed in words but felt in the countertransference. Transference can be stimulated by the first communications at the referral stage, by the environment and the attitude and approach of the person conducting the interview.

This reinforces a sensitive approach as the questions ask for a personal response. I was aware that the participants in the study would be vulnerable, given why they were referred to the clinic. I also considered that parents were in a vulnerable phase as parents of babies and infants and, therefore, in a relational phase characterised by high dependency.

It was a difficult question to ask. This may suggest that the transference evoked a

sense of anxiety in me as a researcher, that I had become overly concerned that guilt could put the participant in touch with painful feelings. It is possible that these two participants unconsciously communicated something they wished to avoid and that I picked up and observed in the countertransference, this being the feelings aroused in the psychotherapist (Joseph 1989).

In the debrief interview, participants were prepared. They answered the questions succinctly and thoughtfully, but I found myself prompting for more information to expand on answers, as I felt concerned at what I perceived to be a brief interview. The length of the PDI interview may have influenced this. If it is too probing to ask the "guilt" question, my countertransference could be a barometer of what felt too much to ask in response to the participant's narrative.

I discovered that some parents had reflected on their experience and given insights into guilt and how these emotions could affect their relationship with their infant. This evidenced that participants drew on their RF following the interview and took their reflections into the assessment. Perhaps I was more sensitive to the impact of the questions than the participant, particularly with the mothers who expressed hateful feelings towards their infants. This suggests the interview picks up on unconscious guilt even if not explicitly asked and held in latent content.

The questions about anger and guilt enabled the participants to express ambivalence and are important questions sensitively asked after building an alliance through the warm-up questions.

4.11. Limitations and strengths of the PDI

A strength of the PDI may be that as a qualitative tool that elicits rich qualitative material, it is designed and produced to get a score from the questions that can verify feasibility and acceptability of the subjective experience. The work with the parent and infant's needs can be challenging given the consistent constraints on time with complex cases and services under enormous pressure of throughput. This may impact the time devoted to a full assessment period if clinicians perceive this as a burden.

Other limitations are described as a 'lack of credible research' and small sample sizes (Fonagy et al. 2016), but this was addressed by Fonagy et al. (2016) in their major study RCT in the UK. Here, the findings from 38 PIP standard and primary groups indicate improved emotional functioning in mothers' well-being and their representations of their infant.

From another perspective, a more thorough assessment tool may save time in the assessment and be of benefit if the parents' RF recommends an ongoing intervention in advance and their main preoccupations. The argument posed in this study is that taking the clinical application of the PDI further to develop service provision and efficacy of the intervention would make a difference despite being a time-consuming resource.

Chapter 5 Discussion

5.1. Reflections on the data

My interest led me to ask whether or not the information gained from the PDI could provide a more detailed understanding of the parent's state of mind and their perception of their infant in preparation for the assessment.

Having completed the study, I believe that the PDI helps the patient and practitioner understand what issues are present during the perinatal period. Information would also be gained on the level of risk that could be present but is difficult to ascertain in the psychometric standard outcomes measures currently used in CAMHs.

Most participants who undertook the PDI indicated it was a positive experience. It was, therefore, feasible in terms of application and acceptable in terms of timing, duration, and the insights gained from increased reflective functioning.

When I began this study, I was unsure if the PDI would be feasible and acceptable to parents referred to the PIP service. It was certainly worth researching - despite the views of some practitioners and researchers that the PDI is time-consuming, burdensome on parents, and costly (Lambert et al., 1996; Borelli et al., 2020).

The capacity of the PDI as a validated measure to access openness in mothers is viewed as a positive indicator when researching high-risk (Glenne et al. 2020, Slade 2005, Slade et al. 2005b, Ruiz, Witting, Ahnert & Piskernick 2019).

Parents experiencing attachment difficulties or personality disorders may go undiagnosed unless they can engage in an extensive assessment. Mental health disorders can cause high levels of despair and confusion that can affect a parent's capacity to parent. This can include unprocessed or unresolved trauma from the parent's background and can compound the mother's mental health problems after she gives birth (Barrows 2003, 2008, p297, Grienenberger et al. 2005b. p5). For example, one particularly troubled participant held hostile attributions, which were projected onto her infant, and she expressed anxiety about safety and loss. This mother had less affect regulation or ability to consider her infants' feelings.

5.1.'Talking in this way using the PDI' with sub-themes Good to talk, could elaborate through questions and informing assessment.

Participants' responses indicated they appreciated an opportunity to express their experience as new parents. Rather than being burdensome, the participants felt that the interview asked relevant questions. These enabled them to identify issues that would need disentangling over time to be understood. This suggests the questions facilitated more depth of reflection. The infant in the mind of the mother is a central theme in parental reflective functioning and considers how the relationship affects the infant's development.

Direct questions about the infant's feelings stimulated more thought in some mothers and identification with their infant's experiences. The experiences captured in the debrief interview generated more information about feasibility and acceptability. The depth of material shown in the findings from the themes indicates that the openness of the researcher can elicit more open responses. This generated the sub-theme of

'talking in this way using the PDI'. The data showed the questions enabled the parent to think about and speak authentically about their relationship with their infant.

5.2. A shift to the infant's perspective with sub-themes 'Infant in the mind of mother', 'Infant-Parent connection', and 'Finding own parenting style'.

Being able to identify with their infant is a central tenet of the parent's reflective functioning and is incorporated into the main theme. Interestingly, in the findings, the parents of young babies discerned their difficulty putting themselves in the minds of their infants. This is discussed in the literature in that it is easier to consider what's in the mind of an infant than a 3-month-old baby (Slade 2005). I found the participants could use the questions about their relationship with their baby to connect with thoughts about how their infant feels. For instance, participant 006 reflected on how her feelings of guilt affected her infant's development. Participant 001 thought reflecting on everything from the beginning as if taking stock as a new parent was good.

Grienenberger, Kelly & Slade (2005) describe how measuring the infant's attachment at 10 months using the PDI enabled them to analyse the strength of emotions dominated by needs in both the infant and mother. They describe how maternal sensitivity can mediate between RF and attachment (p 38). This could be seen in participants with older infants who became conscious of how their behaviour influenced their infant; this was particularly noticeable with participant 002, who thought about how her shouting made her infant feel. Balbernie (2022a) links the mother's difficulty in thinking about her infant's feelings with the lack of mental space in the mother's mind.

The PDI was thought to enhance the mother's tendency to idealise the relationship, as discussed by Baradon et al. (2008). This linked to unresolved childhood problems, evident in the data whereby participants, in particular 004, wanted to impress on the researcher her capacity to parent her baby. The structure of the questions enabled participants to revisit these thoughts and shift to the infant's perspective.

5.3. 'Integration and change', with sub-themes of 'felt cared for, 'Stayed in mind', and 'Thinking in a different light'

This theme supported openness and honesty but raised other questions about when the parent has a gridlock of projections onto the child, causing a misrepresentation of the infants' behaviour. Here, it could be hard to make any impact on RF.

The findings suggest participants felt they were collaborating with the researcher rather than having something done to them that was out of their hands. They could see the changes as it dawned on them that they were thinking in a new light. This notion of 'seeing' or 'thinking 'encompassed the capacity to reflect on the past and link with the present.

The question arose as to whether this is sustainable without the assessment. Still, suppose the PDI was an intervention and a conduit to integrating new awareness. In that case, this implies that as an assessment tool, the theme of a 'shift to the infant's perspective' would elevate thinking to a level of reflective functioning needed, thereby making the unconscious conscious.

The question about anger and guilt will cause struggles in parents, whether biological or adoptive, to express ambivalence. Although guilt was implied throughout the interview, as discussed, it may be a neglected area among mothers who express their hateful feelings towards their infants. Hatefulness is a natural defence in mothers and not unexpected in healthy parent-infant relationships. Having the opportunity to filter ambivalent feelings through the PDI could be very beneficial for adoptive parents struggling to raise their adoptive children when they feel they cannot be seen to fail as parents.

Perhaps I was more sensitive to the impact of the questions than the participant, particularly with the mothers who expressed hateful feelings towards their infants. This suggests the interview picks up on unconscious guilt even if not explicitly asked about it and was held in latent content.

5.4. The PDI in Practice

In answer to the question posed in this study, the outcomes helped us achieve a more accurate understanding within a CAMH's setting of the parent's needs and the challenges in developing their relationship with their infant. Improvements in care service initiatives for the parent-infant relationship are vital to promote change. However, what does it mean in practice?

If the PDI rating indicates that the parent has a low reflective function, then conducting 'before and after' PDI interviews would have the potential to measure if the intervention increased RF or if the parent's potential to reflect remains limited for whatever reason. Another question raised is whether the PDI, as an integrated part of the treatment at

the assessment stage, can act as an indicator or guide for the parent and therapist as to what the work might be about.

Like Ransley et al. (2019), I, too, recommend developing a questionnaire to use in conversation with parents/carers before the intervention. This recommendation is borne out in the findings that a discussion guided by the questions did enable free-flowing elaboration 'like a chat' and could inform the basis of the assessment. This theme suggests the PDI was acceptable and helpful in promoting further exploration of the parent-infant relationship and the barriers that may impede bonding.

The Ransley et al. (2019) research drew the most relevant correlations between assessment and PIP from two RCTs using the PDI (Slade et al. 2004) with a 12-month home follow-up. There are no guidelines on the optimum period to complete a follow–up. It is a judgement call biased by research design, as implied from past research studies. Findings from the Ransley et al. (2019) study stated that improvements in RF were not dependent on whether or not the mothers were willing to discuss their childhood. This has implications for using the PDI as an assessment tool in that measuring RF can yield meaningful results based on the participants' experience and not just the outcome from the coding.

On reflection, the Ransley et al. (2019) study outcomes may indicate similar results to the findings in this study in that all the mothers interviewed were at a stage of positive transference built on trust.

It is possible that this kind of measurement relies on parents having a positive transference and raises questions about the timing of conducting the assessment tool. This measure needs to be part of a longer process to monitor RF at the assessment phase to give baseline data for when the work concludes. A particular undertaking is necessary to establish a trusting relationship before conducting the PDI. Interestingly, it is helpful to have some therapeutic alliance already established through the PDI, though not a prerequisite with psychometric tools, where the interviewer and participant come in cold, so to speak. Researchers who are more restrictive by just superficially asking the questions do not go 'off-script' or give no examples to help the participants and may elicit less material to support the assessment. This may be experienced as unfriendly by parents and could limit their responses, particularly for parents resistant to acknowledging how their behaviour may affect their relationship with their infant.

In the Literature review, parenting representations have focused more on mothers and fathers deemed 'at risk'. Variants in hard-to-reach populations include socioeconomic adversity, in custody, illicit substance addictions and mental health problems. This demonstrates that research studies met the most ingrained and complex areas head-on (Baradon et al. 2008; Pajulo et al. 2012; Sleed et al. 2018; Fonagy et al. 2016). By implementing the PDI, these studies predicted future disorganised attachment problems. Researchers consistently indicate how mothers with low RF are unlikely to use their own internal experience to guide their understanding of their child's experience (Slade 2005; Sleed et al. 2018; Glenne et al. 2020). Mixed results in empirical research in the area of change are a prevalent theme in the study. The qualitative analysis identified openness to change (Cramer & Stern 1988) to promote

early relationships (Fonagy et al. 2016), a culture of change (James 2002, Jones 2006, Barrows 2008), and possibilities for change in the early relationship (Urwin 2003). This concurs with the findings on the theme of change and integration.

The effectiveness of the intervention and service provision in promoting change and measuring RF is a predominant feature in the research (Fonagy et al. 2016; Miller et al. 2003; Emmanuel et al. 2014). No evidence specifically on the effectiveness of the Parent Development Interview in CAMHs exists, which is to be expected for the reasons addressed in this study.

I was concerned that the PDI in practice might negatively affect participants' mental health. However, one participant spoke of not thinking any further about it afterwards. This could be a disavowal of the emotional experience to protect from dwelling, but comments show it was helpful to think about the relational changes and progression made in bonding. Some ethical considerations and judgements on timing are needed as to which participants have the mental capacity to cope with the probing 'demand' questions. The manual states that 'probing' individuals with limited responses might anger them. Too much intervention could affect their natural pattern of responsiveness (2019 manual). It is a sensitive balance and essential to hear the story as it is told. The PDI could verify where the concerns are focused and what work is needed in the therapy, but outcomes should never be used to concern the participant. As it was, none of the participants asked for feedback from the PDI or the debrief, suggesting participants' experience was contained or could be explored in the assessment.

On a related note, it felt necessary to close the interview with an ending pre-amble as the last question ends the interview abruptly when asking about the experience of loss, separation and what participants would change. This may be jarring for parents who have shared personal details and feel held in the ambience of the interview. This also raises the question of the need for the interviewer to have an open and approachable stance adaptive to the parents'; without this, the process could feel intrusive and stirring. It must be ethical and consider the parent's experience of the PDI. I propose that the PDI is a safe way, like Stern's' Ports of Entry' (1995), in that the structures of the PDI act as 'third' making space to 'open up'.

5.5. Strengths and limitations of this study.

Limitations

The main drawback of this study is the underrepresentation of diversity and ethnic groups in my sample. This was partly due to the need for more diversity of Service Users in the CAMH service, limiting this study to a homogeneous group. This will affect the findings because similarities were more apparent than differences, not just to each other but also to the researcher. This was disappointing and a consistent issue that needs addressing to reach out to diverse communities in the locality to improve access.

It was also unfortunate that no fathers were interviewed. This was circumstantial rather than preference. The underrepresentation of fathers in EYS generally suggests a self-perpetuating problem. Comparisons between mothers and fathers, even same-sex partnerships, are complex, given parents' different roles with their infants. As discussed in the findings, absent fathers were present in the mother's mind, even when

a partner was involved in the infant's care. Researching how diversity, including the role of fathers, could ascertain the differences in RF when rating the PDI could provide more varied results. The findings only indicate outcomes related to a narrow demographic and do not inform the experience feasibility of acceptability to a diverse sample. Despite the range in age and socioeconomic factors, each participant was of a similar ethnic minority group.

Another limitation of this study is my dual role as interviewer researcher in carrying out the interviews and the rating. Arguably, the objectivity lost could have been retained if an independent rater was used. On the other hand, the strength of my holding both roles allowed a relationship to be built up to support trust, thus creating a scaffolding that enhanced the interview and gave rich material to code.

Leaving the PDI ratings out of the thesis was a limitation of this study. It is important to emphasise that the focus was not on the attributes of the PDI as a measurement tool but on participants' experience of the PDI. It was integral to rate the transcripts to compare with the outcomes from the TA but beyond the scope of this study to include the rater results. The interview influenced some of my rates and codes, my recall, the transference and countertransference, where I either did not give credit for the participants' capacity for RF or was drawn into the halo effect and over-credited the RF. From the 2019 manual, this seems inevitable where psychoanalytic processes are at play, such as projection, splitting, idealisation and resistance.

Strengths

The interview's influences helped me better understand what benefits the PDI could have for the participant in their assessment. A strength of this study is that the PDI was rated and second blind rated by an independent rater. This validates the accuracy of the codes and subsequent ratings ascribed to each transcript.

My experience of rating the PDI and reviewing the second-rated PDI was the learning applied to my findings. I could see where I coded correctly and my discrepancies. It was essential to have a second blind rater to validate the codes. In some cases, the low RF was concerning as my inexperience made me question if I was unconsciously penalising the participants. Still, on reflection, the comments from the second rater helpfully compared the entire coding outcome and where the low rates were focused. This helped me understand that the coding was fair and accurate. Before coding, I conducted 'dummy' ratings in preparation for the actual coding.

Inter-rater reliability seems to emphasise that blind rating enables scores to be less influenced by the interview experience. A downside is that it is expensive to commission an expert second rater from the Coding Consortium but a worthwhile expenditure, given the importance of accurate coding.

Whilst coding, Michelle Sleed, senior PDI researcher, requested our permission to send one of the transcripts to Arietta Slade, PDI researcher originator, as it was thought to be a good sample of a complex PDI that raises particular concerns that are not picked up in the adapted PDI. It was to be used in her subsequent adaption of the manual. I, too, found it complex and difficult to code. The final rate was extremely low, which had been originally anticipated. Having rated and coded the PDI, the second

rater verified it before the transcript was sent to Michelle Sleed for a third rating. This experience generated the kind of information needed to inform the assessment and recommendations for ongoing treatment.

None of the PDIs was unduly concerning, but I considered whether participants presented risks and how we use the PDI scores to highlight these concerns. I am also pleased that unlike Urwin (2003), as discussed in the literature review, who reported on the underrepresentation of babies under 18 months old, this study included infants from 3 months to two years old, which could be considered a strength of the data analysis.

Chapter 6 Conclusion

It is important to acknowledge that this study is more weighted towards the participants' experience than the service. However, both were balanced when thinking about the aims.

In this research, I aimed to understand if the manualised PDI measure (version 1991) was feasible and acceptable for the Early Years' CAMHs service to use as an assessment tool, and to learn about the parent's experience of the semi-structured interview. It was necessary to code and rate the transcripts to ascertain that rating was a valuable part of the process.

The central question of whether the PDI would help to inform the assessment was positively indicated. A caveat is that parents' mental health and vulnerability, as well as timing and pace, are considered carefully before conducting the PDI. The literature review indicated that analyses of participants' experiences and impressions of the PDI are lacking in current studies. The literature discusses the PDI experience as a measurement tool to seek outcomes but does not examine the effect on the participants.

The research suggests the feasibility of the practical element of the PDI indicated by the themes that participants thought it was acceptable to be conducted within a CAMH service and that they would welcome this approach before the assessment.

The research suggests that conducting the practical element of the PDI was feasible within the CAMH service and that the participants found it acceptable for it to be completed prior to their assessment. Although some found it emotionally difficult, it

was considered that the benefits outweighed the drawbacks. The training costs and time needed to code results would be more difficult for this small service to deliver.

From the participants' responses in the themes, the research also indicated that the PDI was acceptable regarding the length of time taken to conduct the interview. Participants highlighted the opportunity to discuss their bonding problems with their infant. The relational scaffolding provided in the interview enabled participants to hold their infant in mind. This helped to consider what participants needed to explore in their assessment. It prepared them well for the next phase and enabled us to capture more detail.

Implications for future research

The most useful research would involve conducting PDI interviews with both larger samples of mothers and fathers and parents from diverse communities. This would balance the underrepresentation of ethnic-majority parents.

The manual states that the model is limited in that it does not permit the regulation of more complex experiences, such as conflict and ambivalence (2019 version, p. 25). The research indicates that the experience of rating and coding complex PDI samples could provide the basis for future research. It would help clinicians to develop and capture more information about high-risk factors and safeguarding measures where necessary. It would also enable clinicians to see the power of the projections that a parent can place on the child, and the need for preventative measurable interventions in Infant Mental Health Services.

6.2. Implications for practice

Since completing this study, my colleague and I have discussed the possibility of

implementing the PDI in the EYS as a routine outcome. The service accepted this. The drawback is the time coding takes, although this becomes quicker with confidence and practice. In the future, I would like to apply for funding to continue researching outcomes used to measure Parent-Infant Psychotherapy interventions.

Further recommendations

The argument posed in this research is that by taking the clinical application of the PDI further to develop service provision and efficacy of the intervention it would make a difference despite being a time-consuming resource. Long-term benefits could be realised by having this information before the assessment. If applying a measure that leaves the participant in mental distress, clinicians should consider whether it is appropriate to use the PDI or whether to conduct more closed-ended psychometrics.

If monitoring RF were part of the responsibilities of a Multi-Disciplinary Team, the reviews would highlight what preventative work should take place. Ploughing resources into the EYS by conducting the PDI at the earliest stage could prevent future complications. For example, what is seen in adolescents referred to CAMHs could well link back to a lack of parental RF (if this was identified at the time). It could be argued that preventative factors can protect against later life problems in adolescence if the presenting issues are addressed in infancy.

In order to be effective, increased resources for EYS must be sensibly and consistently managed. By embedding the process in the network and developing a positive transference to the service, a positive start to RF could take place and increase the likelihood of healthy parenting. This would be helped by developing good

communication between the EYS and Health Visitors, Paediatricians and Midwives. Training to conduct the PDI is mandatory, and my experience of the training raised many issues. These included:

- the importance of using clinical judgement;
- the need to assume the role of interviewer;
- ethical considerations regarding the interviewee's mental health; and
- judging when it is appropriate to conduct the interview, if at all.

These needed to be addressed in the research and raised questions about how Parent-infant Psychotherapists conduct measures in Early Years work. Introducing the PDI and applying it more generally as an open-ended RF measure requires it to be used at a timely point in the assessment process and at the follow-up.

The ratings also show reflective development and could indicate progress. However, this could also equate with the parents' attempt to fit with the therapist's expectations or may be a consequence of the parents' increased ability to acknowledge their difficulties. Ultimately, this would be an indication of a positive outcome of the PDI in preparation for the PIP assessment and indeed, ongoing psychotherapy.

Conducting this study has enabled me to feel more confident in my PIP work as a consequence of the research. It has helped me to think in more depth about the impact parents have on their infants, and what impact the infant has on their parents. The research has also helped me to appreciate the parent's response to their infant's distress and how this is informed by the parent's experiences in infancy.

By immersing myself in this study, I had a valuable experience learning more about a parent's investment and desire to understand more about their relationship with their infant and the support they are seeking to develop their confidence as a new parent. My experience has helped me build on my confidence as a researcher and the important role research plays in the field of Parent-Infant Psychotherapy.

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APPENDICES

Appendix 1

[Table 1] Sample Category 1.

Sub-theme	Sub-theme	Clustering sample	illustration
Talking in this way using the PDI	***Setting the pace***	Felt looked after Given time Not rushed Cared about Went over a lot of ground Timing right	"No it was about right." "I think there was definitely enough time to cover everything in detail". "Yeah, I don't think it was rushed" , " you offered a break" "I could understand because obviously with dyslexia it makes it harder, it was very clear to understand"
	Good to talk/could elaborate on questions	Like therapy but not therapy Positive reflective space Not thinking Hadn't thought more Did not stay in mind Frees up discussion Progression Can see link/pattern/the familiar Pertinent/relevant	"I was able to kind of elaborate on stuff that I wanted to talk about, and it made me think about things in a different light to how I would every day". "I think it was very, it was very therapeutic. Really, it felt like a like a chat, even though it had a clear structure".

			"it felt a bit like an intense therapy session"
	Informing assessment	Right time before assessment Helpful to explore more Sooner than later Accessible. Available Opening up conversation Thinking together	"So I can discuss my feelings of guilt with (therapist) for instance, because that's something that I definitely took away from that that my guilt is actually something that's quite important to discuss".

Appendix 2

(Table 2) Sample Category 2

Sub-theme	Sub-theme	Clustering sample	Illustration
A shift to the infant's perspective	***Infant in mind of mother***	Impact on infant thought about/not thought about. Direct questions about infant's thoughts and feelings stimulates new realisations. Age of infant in mothers mind affects interview. Identifying with infant. Future development	"I think all the questions were definitely things that made sense to ask but there were things that I hadn't really thought about, about how my relationship with (child) is affected by my emotions"
	Infant-parent connection	Progression, Change, Enlightening,	"it made me realise that all these things

		Aspiration to be a better parent. Thinking rather than action, Integrated view of parenting, Developmental impact, Learning from experience, Needs father figure, Deeply buried emotions, Anxiety adjusting to new parenthood. Patterns from childhood experiences,	affect my relationship with (child), and they're all something that I need to explore a little bit." "I can't actually tell what he does and doesn't understand really... so there is that kind of ...an the interview did kind of like bring up a few things that I hadn't necessarily really thought of"
	Finding own parenting style	Different to parents. Learning from parents, Intergenerational transmission. The past in the present. Preventing trauma cycle.	"… that kind of made me like look at my parents in a different perspective, or like fresh eyes in a way because like it opened up a lot…" "I want to be very different from my parents". "I've been carrying that forward, like during the generational kind of pass on, and which is something that I always said that I never wanted to do".

Appendix 3

(Table 3) Sample category 3.

Sub-theme	Sub-theme	Clustering sample	Illustration
Integration and Change	***Felt care for and nurtured***	Stimulating- interview, insights, thoughts, new awareness, new possibilities, progress Thoughts Thinking Opening mind New insights: enlightening into mother/infants emotional state.	" it is definitely important…if you have an interview with an interviewer to be personable. I think you definitely were" " I think it felt like a non-threatening environment. It felt accepting, "I didn't feel like I couldn't say things..I could open up"
	Stayed in mind	Recognising what was not noticed. Change evident. Deeply buried thoughts accessed. Integration- thoughts and feelings. Not staying in mind.	"I think it made me open up a different emotion that maybe I've shut out for a long time". "I was able to recognise that I felt vulnerable in that area. I could then say that aloud". "Whereas before maybe I hadn't even questioned that or thought about that".
	Thinking in a different light	Stimulating. Thinking differently	"it was good to reflect as such

		New awareness. Relevance. Insight. Seeing more. Thoughtful.	because I've don't really think like hadn't really gone over anything from the beginning". "Whereas before maybe I hadn't even questioned that or thought about that".

Appendix 4. PDI Reliability Certificate

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Reflective Functioning of the Parent Development Interview: Reliability Test

To Whom It May Concern:

This is to certify that
Kate Rothwell
Successfully completed the Reliability Test in June 2019.
This certificate authorises Kate Rothwell to utilize the Reflective Functioning Scale for Clinical and Research Purposes. It also allows publication and presentation of research data obtained using the Reflective Functioning Scale.

Signed:

……
Michelle Sleed
Course Leader

Our Patron: **Her Royal Highness The Duchess of Cambridge** The Anna Freud National Centre for Children and Families is a company limited by guarantee, company number 03819888, and a registered charity, number 1077106.

Appendix 5. Participants Letter of Thanks

Post-study information

Dear

Thank you very much for taking part in my study.

Your contribution is greatly valued and I hope this study will help me understand what it was like for you engaging in the interview. I hope you also found the experience useful and interesting.

I wish you and your infant well during your experience at CAMHs in the parent-infant psychotherapy service.

If you have any unforeseen questions or concerns that may arise for you now the study has ended, and you would like to speak with someone, please do contact me:

By telephone: 07551676222

By email: kate.rothwell1@nhs.net

By post: At the address above.

With thanks, and best wishes

Kate

Kate Rothwell

Specialist trainee Child and Adolescent Psychotherapist

Appendix 6. TREC Letter of Authorisation

The Tavistock and Portman NHS
NHS Foundation Trust

Quality Assurance & Enhancement
Directorate of Education & Training
Tavistock Centre
120 Belsize Lane
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Tel: 020 8938 2699
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Kate Rothwell

By Email
1 March 2021

Dear Kate,

Re: Trust Research Ethics Application

Title: Can the Parent Development Interview be useful in routine practice in a CAMHs Parent-Infant service?

I am pleased to inform you that subject to formal ratification by the Trust Research Ethics Committee your application has been approved. This means you can proceed with your research.

If you have any further questions or require any clarification do not hesitate to contact me.
I am copying this communication to your supervisor.
May I take this opportunity of wishing you every success with your research.

Yours sincerely,
Paru Jeram
Secretary to the Trust Research Degrees Subcommittee
T: 020 938 2699
E: academicquality@tavi-port.nhs.uk
cc. Course Lead, Supervisor

Appendix 7. GESCE Letter of Approval.

Private and Confidential
Kate Rothwell
Child Psychotherapy Doctoral Trainee (EBT3)
Child & Adolescent Mental Health
CAMHs
[redacted]

Consultant Psychiatrist & Medical Director
Honorary Professor of Psychiatry
[redacted]

Governance and Ethics Committee For Studies and Service Evaluations
Email: [redacted]
Website: [redacted]

20th August 2021

Dear Kate,

G2106b - Can the Parent Development Interview (PDI-RF) be useful to inform routine practice in a CAMHs Parent-Infant Psychotherapy service to provide additional insight in the assessment?

Following our review of your proposal by ELFT'S Governance and Ethics Committee for Studies and Evaluations (GECSE)

I am pleased to confirm the above named proposal is compliant with Trust standards.
Once completed, please provide a copy of your results with a summary of the impact on your services so we can celebrate our achievements at ELFT.

With Kind regards,

On behalf of GECSE

[redacted] MD FRCPsych

Appendix 8. Local NHS consent from the CAMHs Senior Management Team.

9th December 2020

Confirmation that trainee project can be undertaken in service

Trainee: Kate Rothwell

I understand that this trainee will soon be ready to start data collection for the research project they will complete during their DProf clinical training programme in Child and Adolescent Psychotherapy. The aims and protocol of this project have been described to me.

I understand that the Tavistock & Portman NHS Foundation Trust are the sponsors of this educational research project and will provide the necessary support and supervision for it to progress.

Subject to final approval by the Tavistock Research Ethics Committee, I confirm that the project as described can be undertaken in this service.

Yours sincerely

Dr [redacted]
Consultant Clinical Psychologist
Lead for Psychological Therapies
Clinical Team Lead - CAMHs Access Pathway
[Schools, GPs, MHST, LAC, BIT, PIP and Early Help]

Child and Adolescent Mental Health Service
[redacted]

Appendix 9. GESCE Risk Table.

Risk	Why	Level	Minimisation
The interview asks personal questions	may trigger an emotional response in participants	Med	Build up a rapport with participants to support them to feel safe and contained whilst being interviewed, and to build a welcoming, non-judgmental environment.
unexpected or adverse outcome arise	participants become distressed during the interview	Med	recommend we take a break, and pause to take a breather. This will be an opportunity to think about what is stressful about the experience.
ensure the interview is conducted at pace set by the participant.	Participants may need further support.	Low	provide Counselling service contact details or make a referral to an alternative service, this may include the community Perinatal service for mothers with mental health needs. I will also provide fathers with information of services they can access in the short term.
participant can engage authentically in the interview.	To put participants at ease.	Low	approach clinically sensitive topics with the utmost care and attention within the ethical parameters of the research study

stay in the bounds of what the participant feels comfortable with	Manage expectations and containment.	Low	discuss with the referrer, if appropriate, and my supervisor, who is the lead child and Parent Infant psychotherapist, to ensure parents needs are given careful consideration whilst accessing the service.

Appendix 10. Participant consent form.

The Tavistock and Portman NHS
NHS Foundation Trust

Participant Consent Form

Date

Can the Parent Development Interview be useful to inform routine practice in a CAMHs Parent-Infant service to provide additional insight in the assessment?

	Please tick
I confirm that I have read and understood 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.	
I understand that my participation or withdrawal from this research will not prevent me from accessing Parent-Infant Therapy.	
I understand that the interview will be digitally audio recorded and then transcribed.	
Should I wish for my data to be removed from the study, I understand that I can utilize the 6 week cooling off period after the interview by contacting Kate Rothwell- email: kate.rothwell1@nhs.net or Tel: 07551676222.	

1809143. Rothwell. Can the Parent Development Interview (PDI-RF) inform assessment in a CAMHs Parent-Infant Psychotherapy service? A qualitative study using Thematic Analysis.

I understand that the information given in this interview may be used by the researcher in future publications, reports, 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.	
My standard of English is good enough to understand and answer interview questions about my life and my experience as a parent.	
I understand that due to the small sample size of the study, it is likely that there will be recognizable data which belongs to me. This is a limitation of the study that I am willing to accept.	

Participant's name:			
Participant's signature:		Date:	
Researcher's signature:		Date:	

Research Identification Number:

Thank you for agreeing to participate in this study.

If you have any concerns relating to the research, please contact:

[redacted]

1809143. Rothwell. Can the Parent Development Interview (PDI-RF) inform assessment in a CAMHs Parent-Infant Psychotherapy service? A qualitative study using Thematic Analysis.

Lead Child & Adolescent Psychotherapist/Parent-Infant Psychotherapist
Child & Adolescent Mental Health Service.
[redacted]

[redacted]

If you have any concerns relating to this research, please contact:

Simon Carrington.
Head of Academic Governance and Quality.
The Tavistock and Portman NHS Foundation Trust.
120 Belsize Lane. London. NW3 5BA. Tel: 020 7435 7111

Appendix 11**.** Participant information sheet.

The Tavistock and Portman NHS
NHS Foundation Trust

Research Project

Can the Parent development interview be used in routine practice in a CAMHs Parent-Infant service?

Are you and your baby visiting the CAMHs Parent-Infant Psychotherapy service for an assessment?

Would you like to take part in research about being a new parent and your relationship with your infant?

You have been given this information sheet because you are being invited to take part in a research project. This information sheet describes more about the research and what taking part would involve.

What is the purpose of this project?

The project aims to explore your thoughts, feelings and experiences as a parent of an infant, and to understand more about your developing relationship together.

Who is conducting the research?

My name is Kate Rothwell. I am a child and adolescent psychotherapist in doctoral training employed at [redacted] Child and Adolescent Mental Health Service and Parent Infant Under 5's service. I am training with The Tavistock and Portman NHS Foundation Trust and validated by Essex University.

What will be participating in the research involve?

If you agree to participate you will be invited to an interview during your assessment. This will be before your first appointment.

The interview will take place at a time and day convenient to you and can be face to face in the clinic or by video link.

Ideally these interviews will be without your baby present. The interviews will be audio reordered. This is to help me as it means I will not need to take notes during the interviews.

Additionally, I will ask you to agree to the use of information routinely obtained from you which you provide to the clinic. This is information on forms or questionnaires used within the Early Years' service and will also include information such as you and your baby's age, gender and ethnicity.

The time commitment will be 90 minutes in order to complete the interview.

I will also like to meet with you after your assessment to ask you about your experience of the interview.

Do I have to take part?

No, it is completely your decision about whether you would like to take part in this research. If you take part, or decide not to take part, nothing will change in the service you and your baby receive from the CAMHs/PIP service. If you agree to take part, you are free to change your mind without giving a reason why.

What will happen to the information I give?

The transcript of the interviews will be anonymised. Any personal details which could identify you or your baby will be removed from the transcript. Any extracts from what you say in the interview that are quoted in the research will be anonymized. I will store information I receive from you during the interviews or from the questionnaires securely and in keeping with the Data Protection Act 1998.

All information that you share during the interview will be kept confidential. The only exception would be if you report feeling unsafe, such as having thoughts to harm yourself or someone else.

In that case I would need to share this information with [redacted], Principle Child Psychotherapist, so that together we can offer you help and agree upon a safety plan with you.

What will happen to the results of the project?

The results will be used primarily for my research study and could be used in published academic papers or academic presentations.

What are the possible benefits of taking part in this research?

There are no immediate benefits to you or your baby. However, by taking part you may discover your strengths and your challenges, which may help if you go on to receive therapy following your assessment.

In particular, I am interested in what happens when parents like yourself ask for help having encountered problems with your relationship with your baby.

Are there any risks?

You may find that the interviews get you thinking about yourself and your baby in a way you may not have thought about before or for a long time. This may stir up some emotions or be unsettling. At the end of each interview I will offer you time, if you require it, to talk about how you are feeling.

If during the interview, you feel you need a break for any reason we can stop and have a moment before continuing.

Contact details

I am the main contact for this project. My contact details are:

Kate Rothwell

Email: kate.rothwell1@nhs.net

Tel: 07551676222

You are welcome to contact The Tavistock and Portman NHS Foundation Trust if you have any concerns about this project. The contact details are:

Simon Carrington

Head of Academic Governance and Quality.

The Tavistock and Portman NHS Foundation Trust.

120 Belsize Lane. London. NW3 5BA

Tel: 020 7435 7111

Thank you for considering taking part in this project and for taking the time to read this information.

If you agree to take part, please complete the consent form.

Appendix 12. Parent Development Debrief Interview- post-interview participant questions

[redacted] **CAMHS Early Years Service**

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

1. Did you think the interview was too long? Too short? Just right?
2. Did you think the interview was relevant to where you are now as a parent?
3. Were the questions understandable?
4. Do you think the interview was helpful for your assessment or not?

Is there anything else you would like to add?

Appendix 13. Parent Development Interview- Reflective Function questionnaire.
(Aber Slade, Berger, Bresgi, Kaplan 1985).
(script).

ID:
Date:

Today we're going to be talking about you and your child. We'll begin by talking about your child and your relationship, and then a little about your own experience as a child. Let's just start off by telling me a little bit about your family- who lives in your family? How many children do you have? What are their ages? (Here I want to know how many children, ages, including those living outside the home, parents, other adults living in the home. If atypical rearing situation (foster care) history of foster placements, who have been primary carers, etc.; likewise, if there appears to be a history of divorce, or multiple moves, get some of the details of that just to create a context for understanding the interview.)

'Permit questions' (warm up)

A: View of the child.

1) I'd like to get a sense of the kind of person your child is, so could you get us started by choosing 3 adjectives (descriptive words) that describe your child.
2) Now let's go back over each adjective. Does a memory or incident come to mind with respect to (name)?
3) In an average week what are his/her favourite things to do? His/her favourite times?
4) And the times or things he/she has trouble with?
5) What do you like most about your child?
6) What do you like least about your child?

'Demand questions'

<u>B. View of the relationship.</u>
1) Can you describe a time in the last week when you and (your child) really "clicked".
Prompt: Can you tell me more about the incident? How did you feel? How do you think (your child) felt?
2) Please can you now describe a time last week when you and (your child) really weren't "clicking"? Prompt: Can you tell me more about the incident? How did you feel? How do you think (your child) felt?
3) How do you think your relationship with your child is effecting his/her development and personality?

<u>C. Affective experience of Parenting</u>
1) Can you describe yourself as a parent? (non coded)
2) What gives you most joy in being a parent?
3) What gives you the most pain or difficulty in being a parent?

4) When you worry about (your child), what do you find yourself worrying about most?
5) how has having a child changed you?
6) Tell me about a time in the last week, or two, when you felt really angry as a parent?
6a) What kind of effect do these feelings have on your child?
7) Tell me about a time in the last week or two when you felt really guilty as a parent?
7a) What kind of effect do these feelings have on your child?
8) tell me about a time in the last week or two when you felt you really needed someone to take care of you?
8a) What kind of effect do these feelings have on (your child).
9) When your child is upset, what does he/she do? How does that make you feel? What do you do?
10) Does (your child) ever feel rejected?

D: Parents family History.

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

1) How do you think your experiences being parented affect your experience of being a parent now?
2) How do you want to be like and unlike your mother as a parent?
3) How about your father?
4) How are you like and unlike your mother as a parent?
5) How about your father?

E: Separation and/Loss

Now I'd like you to think of a time you and your child weren't together, when you were separated. Can you describe it to me? (2 score- parents and child's experience).

1) Has there ever been a time in your child's life when you felt as if you were losing him/her just a little bit? What did that feel like for you?
2) Is there anyone very important to you who (your child) doesn't know but who you wish he/she was close to?
3) Do you think there are experiences in your child's life that you feel have been a setback for him/her?

F: Looking behind, Looking ahead.

1) Your child is (age) already, and you're an experienced parent (modify as appropriate). If you and your child had the experience to do it all over again, what would you change? What wouldn't you change?

Is there anything else you would like to add?

Thank you very much!

Appendix 14. Parent Development Interview- clinician individual debrief questionnaire.

1. Did the results from the PDI semi-structured interview contribute to the assessment?
2. Would the results influence your approach to the assessment or therapy practice?
3. Were there any benefits to having the information prior to/ during the assessment?
4. Would you like to see the PDI used in routine practice?

Is there anything else you would like to add?

Appendix 15. PDI studies Table

Author/Researcher	Date	Research	Sample	Qualitative
Slade, Phelps, Aber & Phelps	1999	Collected 150 PDI's. Assessed mother's representations of their infants. No control group	Rural, married Caucasian families.	Longitudinal.
Slade, Belsky & Crnic	1999	PDI-RF No control group	Diverse high- low risk mothers and sons (between 15-28 months).	Longitudinal
Slade et al	2005	PDI-RF	Middle class Caucasian first time mothers.	-
Slade et al	2005b	PDI-RF.	Highly diverse highly educated mothers averaging 31 weeks gestation.	Mixed methods. AAI conducted -2nd visit at 10-14 months Stranger Situation conducted- final visit at 28 months.
Grienenberger, Kelly & Slade	2005	PDI-RF	Mothers	Measuring infant's attachment at 10 months old.
Steele, Henderson, Hodges, Kaiuk, Hillman & Steele	2007	Adapted PDI-RF	Used to assess parental RF in pre-adoption families.	Mixed methods. Used Adoption Expectations Interview (AEI) version adapted from PDI
Baradon, Fonagy, Bland, Lenard & Steele.	2008	PDI-RF	75 ethnically diverse mother and baby dyads in control. 88 in intervention group. Used PDI to measure impact of intervention.	Longitudinal RCT in mother and baby units in UK female prison settings. Group intervention programme 'New Beginnings'. Control group. Mixed methods using battery of measures, inc: MORs.
Pajulo, Pykkonen, Kalland, Sinkkonnen, Helenius, Punamakiir & Suchman	2012	PDI-RF	PDI used to assess if RF is an agent of change in high-risk substance dependant mothers.	Mixed methods
Smith, Stover & Kiselica	2014	Revised PDI-RF	Substance dependant fathers with problems with violence.	No control group
Ordway, Sandler, Dixon &Slade	2014	PDI	Parental RF and Infant attachment measured in	No control group

			nursing profession	
Fonagy, Sleed & Baradon	2016	PDI-RF	Mothers experiencing mental health problems, low level socio-economic deprivation and complex familial pressure from urban demographically diverse population.	RCT. 38 allocated to PIP intervention and 38 to control treatment as usual group.
Sleed, Slade & Fonagy	2018	PDI-RF	Analysing psychometric properties of PDI with a population of low, medium and high-risk socio-economic demographic factors.	3 control groups 1) Normative 2) Clinically referred 3) Mother and baby prison unit.
Ruiz, Witting, Ahnert & Piskernick	2019	PDI-RF	Mothers and fathers of pre-term and full term infants assessed. 322 parents- 59% 'pre-term' infants, 55% full-term- 12-20 months old.	No control group.
Ransley, Sleed, Baradon & Fonagy	2019	PDI-RF measured at pre-assessment phase with 12 month post follow up.	61 highly diverse dyads over 12 month period.	Empirical evidence used from 2 RCTs. Mixed methods and different control conditions. TA used to identify themes from semi-structured interview related to willingness to discuss childhood.
Glenne, Ingebjorg, Horndalsveen, S"oderstr'om, Ystrom & Hakansson	2020	PDI-RF used as assessment tool.	Mothers with high-risk SUDs.	No control group
Mennashe-Grinburg, Scneor, Meiri & Atzaba-Poria	2020	Adapted PDI-RF	Wide diversity. Weekly group intervention (DUET) parenting model	Empirical studies replicated
Carlone & Milan	2021	PDFQ- self-reported questionnaire	Measured parents capacity to engage in health services	-