Mothers' experiences of change in parent-infant psychotherapy for infants with feeding difficulties: An Interpretative Phenomenological Analysis

Rocio Ayala Gonzalez

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Tavistock and Portman NHS Foundation Trust

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Abstract

Although Parent–infant Psychotherapy (PIP) has demonstrated some effectiveness in improving infant attachment security, maternal representations and maternal mental health, not much research has examined how parents themselves experience change, particularly in the context of infant feeding difficulties. This doctoral study explores mothers' lived experiences of change during PIP delivered within a specialist Parent-infant Feeding Clinic (PIFC) in an NHS Perinatal Parent-Infant Mental Health Service in England.

Using Interpretative Phenomenological Analysis (IPA), in-depth semi-structured interviews were conducted with four mothers of infants aged approximately 6 months to 3 years who had completed at least six parent infant psychotherapy sessions within PIFC. The analysis generated a set of Group Experiential Themes capturing both pre-therapy contexts and processes of change.

Mothers described entering therapy in states of crisis, marked by anxiety, guilt, and relational rupture around feeding. Feeding difficulties were experienced as threats to maternal identity, confidence, and the developing parent-infant relationship. Change was described as gradual and relational, emerging through therapeutic containment and the restoration of reflective capacity. The more mothers felt emotionally held, the better able they were to reinterpret their infants' communications, leading to shifts in feeding interactions alongside broader relational changes, including increased confidence, emotional regulation, and renewed connection.

The findings illuminate experiential mechanisms of change in PIP beyond symptom reduction, highlighting the centrality of therapeutic containment and reflective processes. By focusing on mothers' lived experience, this study contributes to the

qualitative PIP literature and offers clinically relevant implications for parent-infant mental health services working with feeding difficulties.

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INTRODUCTION

PROLOGUE

Aims and Objectives

This study explores the lived experiences of change during Parent-Infant Psychotherapy (PIP) for parents of infants with feeding difficulties. Specifically, the study seeks to:

- Explore how parents perceive, understand and make sense of change during PIP.
- Identify where parents locate change, whether in the infant, the parent, or the parent-infant relationship.
- Examine factors that facilitate or impede change, including internal and external barriers, and how these shape the therapeutic process.
- Understand parents' expectations of change and how these may evolve over time.

In addressing these aims, the study aims to understand parents' subjective experiences, offering insight into how PIP is perceived to work and how it promotes change from the perspective of those receiving the intervention.

Context of the Study

This qualitative research was conducted within a specialist parent-infant mental health service operating in an NHS community setting in England. The focus was the Parent-Infant Feeding Clinic (PIFC), a specialist intervention offering PIP to families whose

infants, from early weaning through to toddlerhood, presented with feeding difficulties in the absence of medical causes.

At the point of PIFC referral, infants typically presented with observable feeding symptoms, while parental mental health difficulties and disturbances in the parent-infant relationship were generally subclinical. Feeding difficulties were conceptualised within a relational framework, with attention given to the impact of unresolved parental trauma and emotional distress on parents' capacity to recognise and respond to their infants' emotional and regulatory needs.

Participants and methodological approach

The study involved semi-structured interviews with a purposive sample of four mothers, each of whom had completed a minimum of six sessions of PIP within PIFC. There was no upper limit on the number of sessions attended. Although recruitment from a single therapeutic setting offered a degree of homogeneity, the sample remained heterogeneous with respect to maternal and infant age, duration of treatment, and case complexity. All participating dyads had experienced forms of perinatal adversity, such as traumatic pregnancies or births, exposure to domestic violence, and infant's health difficulties. These experiences appeared to shape their early relational context, with potential implications for emotional availability, attachment, and the emergence of feeding difficulties.

Interpretative Phenomenological Analysis (IPA) was selected as the analytic approach, given its emphasis on exploring in depth how individuals make sense of significant lived experiences. IPA was considered particularly well suited to examining parents' subjective interpretations of therapeutic change within the emotionally complex context of parent-infant psychotherapy.

Rationale for the study

To date, the evidence base for parent-infant psychotherapy has been dominated by quantitative research, with findings remaining mixed and, in some cases, tentative. For example, while some studies have reported improvements in attachment security or parental mental health following PIP, evidence for its superiority over standard care or alternative interventions has been limited. These findings highlight the need for further research that moves beyond outcome measurement to examine the processes through which change may occur.

Qualitative research on PIP remains relatively limited, although emerging studies suggest that factors such as parental expectations may play an important role in shaping therapeutic outcomes. Exploring parents' lived experiences of PIP therefore offers the potential to understand more nuanced aspects of therapeutic change that may not be accessible through quantitative methods alone. Such work aligns with broader healthcare priorities (NHS England, 2019) emphasising the importance of patients' perspectives in the development of mental health services.

My initial interest was broader, focusing on parents' experiences of change within PIP across different clinical presentations. However, as the project developed, practical considerations around recruitment and the availability of participants led me to focus specifically on parents whose infants had presented with feeding difficulties within the Parent–Infant Feeding Clinic (PIFC). What initially emerged as a pragmatic narrowing of the study subsequently became an important area of interest in its own right, offering an opportunity to explore therapeutic change within a particularly complex relational and developmental context.

Although the question of how change occurs in psychotherapy has long been central to clinical enquiry, few studies have explicitly examined parents' experiences of change within PIP, particularly in the context of infant feeding difficulties. This study addresses that gap, aiming to inform clinical knowledge and practice in parent-infant psychotherapy as well as local service development.

RESEARCHER POSITIONING

During my doctoral training in child psychotherapy, I began working within a specialist perinatal parent-infant mental health service. This clinical experience fostered a growing professional and academic interest in the evidence base for Parent-Infant Psychotherapy (PIP), particularly in relation to how outcomes are conceptualised and evaluated across quantitative and qualitative research. I became increasingly interested in what is currently known about how PIP works and where gaps in understanding remain.

During this period, I was also becoming a mother for the first time. The intersection of my personal experience and clinical training brought an awareness of the emotional complexity of early parenthood. While often characterised by moments of intimacy, growth, and transformation, this period can also involve significant physical, psychological, and social challenges. Working therapeutically with mothers and infants became a source of both professional meaning and reflective learning, deepening my appreciation of the preventative and relational focus of PIP.

At the same time, I became increasingly aware of the potential for my positive valuation of PIP to influence my engagement with the research process. Recognising this, I engaged in ongoing reflective consideration of my assumptions and expectations. I reflected on the importance of approaching the research with openness and humility,

drawing on psychoanalytic ideas that emphasise the need to suspend preconceptions and to tolerate uncertainty, letting go of “memory and desire” (Bion, 1962). Throughout the study, I sought to remain attentive to participants’ lived realities, including those accounts that diverged from my own clinical expectations.

My clinical experience also highlighted that PIP remains a relatively young and evolving intervention, delivered by practitioners from a range of professional backgrounds. While it holds considerable promise, there is still limited understanding of how, for whom, and under what conditions it may be most effective. In practice, PIP often appears to reach a particular subset of parents—typically those already receptive to psychological support and concerned about their relationship with their infant—raising important questions about equality of access and inclusion.

Finally, although the literature frequently emphasises the importance of involving fathers and partners in parent-infant psychotherapy, this remains challenging to implement consistently in clinical settings. Similarly, there is a recognised need for greater cultural sensitivity and inclusivity in working with families from ethnic minority backgrounds and with younger parents.

CHAPTER 1. LITERATURE REVIEW

1.1. RATIONALE

Interpretative Phenomenological Analysis (IPA) is an idiographic and inductive approach, grounded in participants' accounts and the researcher's interpretative engagement with meaning. However, IPA does not require researchers to be "theory-free," and there is recognised variation in when and how the literature is engaged. Some authors advise delaying extensive literature review to minimise the risk of premature conceptual closure, while others argue that careful engagement with relevant literature can strengthen transparency, situate the study, and support analytic sensitivity.

In this thesis, a hybrid approach was adopted. First, a narrative review is used to establish the developmental, theoretical, and clinical context for Parent-infant Psychotherapy (PIP). Second, a more focused review is provided of recent empirical research—both quantitative and qualitative methods. Throughout, the literature is used reflexively: to contextualise the study and clarify the gap it addresses, rather than to predetermine the meaning of participants' responses.

Accordingly, this chapter is organised into three interrelated sections:

1. **Child development research and parent-infant mental health** as the foundational frameworks underpinning parent-infant interventions.
2. **Parent-infant Psychotherapy (PIP)**, including its theoretical foundations and a critical review of the key quantitative and qualitative evidence base.
3. **Infant feeding difficulties and the application of PIP**, with particular attention to the Parent-Infant Feeding Clinic (PIFC) as a specialised adaptation within this field.

1.2. THEORETICAL AND DEVELOPMENTAL FOUNDATIONS OF PARENT-INFANT INTERVENTIONS

1.2.1. CHILD DEVELOPMENT RESEARCH

Contemporary child development research conceptualises infants as socially oriented from birth, with capacities for reciprocal engagement and early intersubjectivity (Trevarthen & Aitken, 2001; Trevarthen, 2004). Parent-infant interaction has been described as rhythmic, coordinated, and affectively communicative, forming the basis of early social dialogue (Beebe, 2000; Tronick et al., 1977).

Affective attunement has been described as a central way in which parents communicate a sense of shared internal states during early infancy (Stern, 1985). Repeated experiences of being responded to in a contingent and meaningful way are understood to support the infant's developing capacity for affect regulation (Brazelton et al., 1974; Fonagy et al., 2002; Schore & Schore, 2008). Parents' sensitivity to infant cues—and the capacity to respond promptly and appropriately—has long been positioned as a key precursor of secure attachment (Ainsworth et al., 1978; Bowlby, 1969).

Related concepts such as mind-mindedness (Meins, 1999) and parental reflective functioning or mentalization (Fonagy et al., 1991; Fonagy & Target, 1997) describe the capacity of caregivers to treat the infant as a psychological subject with an emerging mind. This stance supports the infant's developing early representations of relationships and expectations of care (Beebe et al., 1997; Stern, 1985). Over time, infants begin to use parents' emotional signals to organise responses to novelty and uncertainty (social referencing), alongside the development of joint attention and intentional communication (Bretherton, 1992).

Importantly, relational development involves not only attunement but also rupture and repair. Misattunements are common in ordinary interactions, and the capacity to restore coordination has been linked to relational security and emerging regulatory capacities (Tronick & Cohn, 1989). From this perspective, interventions that support caregivers' capacity to notice, tolerate, and repair disruptions are developmentally meaningful, particularly when families face stressors that compromise sensitivity, mentalising, or emotional availability.

1.2.2. Psychoanalytic theory's influence on child development research

Psychoanalytic traditions have long emphasised the formative role of early relationships in shaping internal experience, including the ways infants manage anxiety, dependency, and separateness. Psychoanalytic object relations accounts highlight how early relational experiences become internalised and later shape relational patterns (Freud, 1940; Klein, 1946; Winnicott, 1965).

Bion's concept of containment, together with reverie and the alpha function, describes how caregivers metabolise infants' overwhelming affective states by receiving emotional communications and returning them in a more manageable form (Bion, 1962, 1967). When this process is compromised, infants may experience severe dysregulation and unmanageable anxiety.

Psychoanalytic and developmental perspectives emphasise that experiences of rupture and repair, when not excessive, can support self-organisation and adaptation to reality, enabling the infant to experience anxiety as survivable rather than overwhelming (Klein, 1946; Winnicott, 1965).

1.2.3. PARENT-INFANT MENTAL HEALTH

Infants' social and emotional functioning cannot be understood in isolation from their relationships, particularly prior to the gradual achievement of separation-individuation (Mahler, 1967; Sameroff & Fiese, 2000). The quality of early parent-infant interaction and the security of infant attachment are key predictors of later neurological, psychological, and social outcomes (Lyons-Ruth, 2008; Schore, 2001; Sroufe, 2005).

Infant mental health (IMH) encompasses health promotion, prevention, and early intervention approaches that support infants' social and emotional development within early relationships (Fraiberg et al., 1975). Central to IMH is the infant's developing capacity to experience, regulate, and express emotions, and to explore the environment grounded in close and secure relationships (ZERO TO THREE, 2016).

Parental mental health difficulties and exposure to psychosocial adversity can compromise parents' emotional availability, sensitivity, and capacity to interpret infant cues, with significant implications for infant regulation and attachment (Schore, 2001; Tronick, 2007). Parental experiences of trauma, loss, chronic stress, or social disadvantage increase the likelihood of disrupted or frightening attachment behaviours, undermining the infant's sense of safety (Main & Hesse, 1990; Lyons-Ruth & Spielman, 2004). Socially disadvantaged groups are at heightened risk of psychiatric difficulties, partly due to reduced access to supportive networks and increased social isolation, which amplify, for instance, vulnerability to postnatal depression (Ban et al., 2012; Brown & Harris, 1978).

Attachment theory underscores the intergenerational transmission of relational patterns, whereby the style of attachment experienced by parents as infants shapes

their responses and, in turn, influences the attachment organisation of their children (Ainsworth et al., 1978; Bowlby, 1969). In particular, unresolved trauma or loss in parents has been consistently associated with an increased likelihood of disorganised attachment in infants, in which the caregiver is experienced paradoxically as both a source of comfort and fear (Liotti, 2004; Main & Hesse, 1990). Insecure attachment has, in turn, been associated with a range of later emotional, behavioural, and relational difficulties (Fonagy et al., 1994; Glaser, 2000).

Infants also bring individual temperamental differences and regulatory vulnerabilities that may intensify parents' demands, particularly in the context of prematurity or early medical complications (Murray, 1997; van IJzendoorn et al., 1992). Early regulatory difficulties—such as persistent problems with crying, sleeping, feeding, and bonding—are among the most common reasons for referral to early mental health services and are associated with increased risk for longer-term regulatory and relational challenges (Berlin et al., 2008; Keren, 2001; Sroufe, 2005). These difficulties are therefore frequently conceptualised as relational phenomena, emerging from reciprocal patterns of arousal, cue interpretation, and co-regulation within the parent-infant dyad.

Taken together, this literature provides a strong rationale for parent-infant interventions that aim to strengthen parents' sensitivity, reflective functioning, and capacities for co-regulation within the parent-infant relationship (Sadler et al., 2006). Such interventions have increasingly targeted both observable dyadic interaction patterns and parents' internal representations of self, infant, and relationship, with the aim of reducing relational risk and supporting infant development (Fraiberg et al., 1975; Knoche et al., 2012; Suchman et al., 2012).

At a service level, UK policy frameworks have increasingly recognised the importance of early parent-infant relationships and the need for investment in perinatal mental health provision (NHS England, 2017, 2019). This commitment is reflected in the government's *The Best Start for Life: A Vision for the 1,001 Critical Days* (Department of Health and Social Care, 2021), which identifies the period from conception to age two as fundamental to children's emotional, social, and psychological development. Building on this vision, the Family Hubs and Start for Life programme aims to improve access to integrated early years services, including infant feeding support, perinatal mental health provision, and interventions supporting parent–infant relationships (Department for Education & Department of Health and Social Care, 2023).

However, despite these policy developments, access to specialist parent-infant interventions remains uneven, and provision has historically prioritises maternal mental health over the parent-infant relationship (Royal College of Psychiatrists, 2018). This gap underscores the ongoing need for interventions that address both parental wellbeing and the quality of early parent-infant relationships.

This study builds on parent-infant mental health frameworks by focusing on a specific and clinically salient relational context: feeding difficulties in infancy. Feeding constitutes a core regulatory and relational domain in which parental anxiety, infant vulnerability, and patterns of co-regulation are often acutely expressed.

1.3. Parent-Infant Psychotherapy

1.3.1. Parent-Infant Psychotherapy

Definition and origins

Parent-Infant Psychotherapy (PIP) has gained prominence in response to increased recognition of disturbances in early parenting, often associated with psychosocial adversity, as well as a growing body of evidence highlighting infants' early relational capacities and the foundational role of early relationships in child development.

PIP is based primarily in psychoanalytic theory as a framework for understanding experience and development, emphasising the centrality of unconscious processes in mental and relational life, while also drawing on attachment theory and child development research (Onions, 2009). It targets early relational disturbances and aims to facilitate change across three interconnected domains: the parent's mental states, the infant's mental states, and the relationship between them (Barrows, 1997). Therapeutic work takes place with the infant present, allowing emotions, mental representations, and unconscious conflicts to emerge within lived interactions (Barrows, 1997). The model is inherently flexible, adapting traditional psychoanalytic settings to the developmental needs of infants and parents, for example by working on the floor.

Psychoanalytic foundations and parental subjectivity

PIP is strongly influenced by the pioneering work of Selma Fraiberg, who emphasised the ways in which parents' early attachment experiences can intrude upon their capacity to relate to their baby in the present (Fraiberg et al., 1975; Hopkins, 2018). When infants come to represent disavowed, denied, or unintegrated aspects of the

parent's own history—or figures from their past—these dynamics may manifest as what Fraiberg termed the "ghosts in the nursery."

Exposure to the infant's primitive emotional states can evoke intense and contagious arousal in parents, activating unresolved affects linked to their own early relational trauma (Raphael-Leff, 2008). This may give rise to traumatic flashbacks, rage, guilt, self-hatred, or overwhelming helplessness, which can inhibit adult caregiving capacities and lead to unconscious re-enactments, including hostility or aggression toward the infant.

From this perspective, the parent's capacity to nurture is shaped by unconscious schemas formed through internalised experiences of care. The baby is therefore perceived and responded to through the lens of the parent's relationship with their own "baby-self," rather than solely as a separate individual in the present.

Development of PIP services and therapist's role

Within the UK, increasing recognition of the importance of early parent-infant relationships within psychoanalytic thinking led to the development of specialist PIP services, including the Tavistock Under Fives Service (Miller, 2008) and the Anna Freud Centre (Baradon et al., 2005).

In PIP, the therapist is conceptualised as a third-party external to the parent-infant dyad, whose role is to help to interpret and differentiate the emotional communications of both parent and infant. The therapist may function as a developmental object therapist (Hurry, 1998) or as a thinking object (Barrows, 2003), supporting insight into emotional and relational difficulties that interfere with the parent-infant relationship (Miller, 2008). This third position may symbolise an "other" within the dyadic

relationship (Miller, 2008) and requires the creation of a reliable facilitating environment (Winnicott, 1965) in which exploration feels safe.

Mechanisms of therapeutic change

PIP aims to work with the “flow of conscious and unconscious communications” (Emanuel, 2011, p. 673) from both parent and infant. Its effectiveness depends on a delicate balance between containing anxiety, ambivalence, and uncertainty; bringing unconscious phantasies into awareness; and disrupting negative transgenerational patterns of relating (Salomonsson, 2014). Without such intervention, these patterns may exert a cumulative traumatic impact on the infant (Khan, 1963).

The therapeutic aim is to support infant development within a compromised primary relationship by creating a new relational experience or affective dialogue between parent and infant (Baradon et al., 2005). In doing so, PIP seeks to interrupt the compulsion to repeat unprocessed, unconscious emotional experiences, whereby what cannot be remembered or understood is instead enacted (Freud, 1914).

Duration and intensity

PIP is often delivered as a short-term intervention, typically ranging from 6 to 20 sessions, reflecting the potential for rapid developmental change in infancy. It is particularly suited to parents who retain some capacity for reflection and help-seeking (Miller, 2008) but are temporarily overwhelmed by the demands of new parenthood and the infant’s absolute dependence (Hopkins, 2018).

More complex relational presentations, including entrenched intergenerational patterns and intense narcissistic projections of uncontained affect onto the infant, may

require longer-term treatment (Barrows, 2003). However, such intensive work is often constrained within NHS settings due to limited resources (Baradon et al., 2005).

The frequency and duration of sessions are shaped by clinical risk, the age and vulnerability of the infant, the impact of therapeutic breaks, and the family's overall capacity for change.

Transference, representations and reflective functioning

In PIP, transference is addressed indirectly, primarily through the exploration of positive and negative transferential dynamics within the parent-infant relationship (Baradon et al., 2005). Countertransference is considered a vital clinical tool, offering insight into whom the infant may represent for the parent, as well as into the emotional states of both parent and infant. Nonetheless, the concept of infant transference remains theoretically underdeveloped (Salomonsson, 2014).

A central aim of PIP is to enhance parents' capacity to reflect on mental states in themselves, in their infant, and in the relationship between them, thereby influencing parent-infant mental representations (Stern, 1995). These representations are particularly malleable in early development, before they become consolidated through repression (Salomonsson, 2014). While maternal perception of the infant will inevitably be distorted to some degree (Aulagnier, 2001), PIP seeks to prevent the escalation of intrusive projective identifications by differentiating the real infant from parents' damaged internal representations. This shift supports healthier reciprocal engagement and longer-term relational change (Sameroff & Fiese, 2000).

Regulation, ports of entry, and technique

PIP supports parent-infant emotional regulation by facilitating modulated stimulation, comfort, and the repair of relational disruptions. Parents are supported to recognise the infant as a developing subject with an emerging mind (Baradon et al., 2005). Repeated experiences of predictable and responsive therapeutic engagement help regulate emotional states and create conditions in which both parent and infant can explore their relationship. This, in turn, helps parents become more attuned to their infant's signals. At times, the therapist may serve as an object for the baby—offering stimulation and emotional regulation—within the context of re-establishing the primary caregiving relationship.

The model draws on Stern's concept of different "ports of entry" into the relationship (Stern, 1985, 1998), allowing flexibility in emphasis on representational or behavioural, aspects depending on the dyad's needs (Cohen et al., 1999). Behavioural scaffolding, modelling, and psychoeducation may initially be prioritised, with representational work developing as capacity allows. In practice, both representational and behavioural approaches are often present, though with differing intensities and priorities, as they are interconnected. Video feedback can serve as an additional port of entry, facilitating parental reflection and responsiveness within the parent-infant relationship (Jones, 2005, 2010).

Family context, culture, and assessment

PIP situates parent-infant difficulties within the broader family system, attending to the role of the father or partner and supporting the development of triadic relationships. It engages with oedipal dynamics and the infant's developmental movement beyond the

dyad (Von Klitzing et al., 1999; Trowell & Etchegoyen, 2002), recognising how the partner may either mitigate or reinforce parental functioning (Woodhead, 2004). Although the partner's involvement is widely acknowledged as just as clinically important (Barrows, 2003), it often remains challenging in practice.

Cultural, racial, and religious contexts are explored with respectful curiosity (Berg, 2005), with attention to how cultural identifications intersect with personal histories of being parented and with potential areas of psychopathology. This included sensitivity to how the therapist is perceived and positioned within the family's cultural world.

Ongoing assessment of the developmental history, affective tone, and interactional quality of the parent-infant relationship is central to PIP, including attention to communication errors associated with disorganised attachment (Beebe & Steele, 2013; Lyons-Ruth, 1999) and infant regulatory behaviours linked to developmental risk (Koulomzin et al., 2002).

Therapeutic process and challenges

Within any session, the therapist may move fluidly between work with the infant, the parent, and the relationship. The therapeutic alliance is considered a central agent of change (Fonagy, 1999). Early stages often involve exploration, modelling, mirroring, and play, while later phases may include interpretation, linking past and present, and reframing. Ending focuses on consolidation and preparation for separation.

PIP aims to enhance parental reflective functioning by introducing new ways of thinking, observing, and making meaning of the parent-infant relationship and interactions. It fosters differentiation between the parent's mental states and those of the baby, which in turn promotes the baby's coherent sense of self and helps prevent

intrusive parental projections. Additionally, PIP seeks to stimulate the infant's interest and reinforce attachment behaviours and contingent responsiveness, facilitating gradual separation and individuation. It is important to openly explore the different hopes and aims of therapy, which may include reducing parental projections onto the child (Barrows, 1997), addressing previous trauma (Cudmore, 2007), and helping the infant communicate feelings.

Key challenges in PIP include attending simultaneously to parent, infant, and countertransference; managing resistance to psychological insight; and navigating parental anxieties that may position the therapist as a threat to the dyadic equilibrium, underscoring the need for specialised training and clinical expertise.

1.3.2. Empirical research in PIP

Search strategy and identification of studies

To identify the most relevant quantitative and qualitative research on Parent-Infant Psychotherapy (PIP), a systematic literature search was conducted using EBSCOhost via the University of Essex. Databases searched included PsycINFO, PsycArticles, PEP Archive, Psychology and Behavioural Sciences Collection, and MEDLINE, enabling broad coverage of psychoanalytic, developmental, and clinical research.

To ensure comprehensiveness, this was supplemented by snowballing through reference lists of key articles and texts, targeted searches via Google Scholar, and consultation of the ETHOS e-theses database to identify recent UK doctoral research. Key journals in the field, including *Infant Mental Health Journal* and *Journal of Child Psychotherapy*, were also manually reviewed. This multi-method strategy was

particularly important for identifying qualitative and psychoanalytically informed studies, which are often under-indexed in standard databases.

Search terms and process

Two groups of search terms were developed. The first (KC1) captured the intervention and population of interest, while the second (KC2) reflected outcome domains and areas of impact.

- KC1: Parent-infant psychotherapy; Mother-baby psychotherapy; Dyadic psychotherapy; Infant-parent psychotherapy; Parent-infant therapy; Parent-infant psychoanalysis.
- KC2: Mental health; Parent-infant relations; Attachment; Infant development; Treatment outcomes; Regulatory disorders; Feeding problems.

KC1 terms were searched using the Boolean operator *OR* and restricted to titles to increase specificity. This search yielded 209 papers. KC2 terms were initially kept broad and expanded iteratively following screening of KC1 results, producing over 2.8 million records prior to refinement. The combined KC1 AND KC2 searches yielded 142 papers.

Limiters were applied for English language and empirical methodology, resulting in 127 papers for title and abstract screening and a final set of 16 empirical studies. Three additional relevant papers excluded by methodological filters were reinstated following manual review, highlighting known limitations of database indexing for qualitative and psychoanalytic research (Appendices A & B).

The papers outlined below were selected as most relevant to the aims of this study. Due to limited space, ten studies (five quantitative and five qualitative) were selected, balancing conceptual and empirical significance.

Qualitative and Quantitative studies

The empirical literature on Parent–Infant Psychotherapy (PIP) includes both quantitative studies examining treatment outcomes and qualitative research exploring parents' experiences of PIP.

Salomonsson and Sandell (2011, 2015) conducted an RCT in Stockholm involving 80 mother–infant dyads randomly assigned to Mother–Infant Psychotherapy (MIP) or standard care. Treatment intensity was participant-led, ranging from 0 to 101 sessions and typically delivered two to three times weekly. MIP was associated with reductions in maternal depression, improvements in maternal sensitivity, and enhanced relationship quality. At a 4.5-year follow-up, children in the MIP group showed better global functioning and fewer behavioural difficulties. However, maternal representations did not change significantly, and improvements were observed in both treatment and control groups, suggesting a possible contribution of non-specific therapeutic factors. Therapeutic alliance emerged as a significant moderator of outcome. The sample was predominantly educated and married, participants were largely self- or nurse-referred, fathers were absent, and treatment exposure varied considerably, limiting the generalisability of the findings.

Salomonsson and Sandell's (2014) findings from a qualitative extension of their RCT provide further insight into this variability. They identified two maternal "ideal types": *Participators* and *Abandoned*. Participators, who focused on relational

concerns, benefited more from PIP, whereas Abandoned mothers—seeking support for their own unresolved distress—sometimes found the analytic stance insufficiently containing. Similarly, Salomonsson and Barimani (2017), who conducted qualitative interviews with mothers approximately six months into Mother-Infant Psychotherapy (MIP), found that mothers valued opportunities to construct coherent narratives connecting past and present experiences, reflect on their developing relationship with their infant, and make sense of their transition to motherhood, although some experienced the treatment as emotionally intense. The absence of fathers was again noted as a limitation. Together, these findings suggest that outcomes may depend not only on treatment exposure, but also on parents' expectations, psychological needs, and the fit between these and the therapeutic approach.

A broader evaluation of psychodynamic PIP interventions was conducted by Barlow et al. (2016) through meta-analysis of eight studies (RCTs and quasi-experimental designs; *n* = 846). Findings indicated that PIP was associated with improvements in infant attachment security, particularly reductions in avoidant attachment in high-risk dyads. However, no significant effects were found for maternal depression, infant cognitive development, behavioural outcomes, maternal representations, or observed interaction quality. Importantly, PIP did not outperform other relationship-based interventions, suggesting that multiple dyadic approaches may be effective via different mechanisms.

Barlow (2007) interviewed 21 primarily white and middle-class mothers, who described PIP as transformative, offering a safe space to process unconscious conflicts, strengthen maternal identity, and develop a more attuned relationship with their infant. Mothers particularly valued the infant's presence within sessions, suggesting that the

therapeutic process was experienced as directly relational rather than solely focused on parental psychological functioning. However, the demographic characteristics of the sample raised questions about the accessibility and relevance of PIP for socioeconomically disadvantaged and minority families.

The tension between measurable outcomes and more subjective or representational forms of change is also apparent in the work of Fonagy et al. (2016). In a study of a manualised PIP intervention with 76 socially disadvantaged mother–infant dyads, no significant group differences were identified in infant development, attachment, or parental reflective functioning. Nevertheless, maternal representations changed, with reductions in hostility and helplessness. Reflective functioning (RF) did not significantly improve, which may partly reflect relatively high baseline levels and limitations in the sensitivity of the measure for this population of mothers already emotionally aware and concerned about their infants as opposed to high-risk samples of mothers who idealize their baby and have more concrete representations (Sleed et al., 2013). Attrition was also higher among younger mothers, raising questions about accessibility and engagement. The authors proposed integrating video feedback to better link representational change with observable parent–infant interaction.

Further examination of engagement within this programme of research adds complexity to these findings. Fonagy et al. (2019) found that increased reflective functioning was associated with parents who prioritised improving the parent–infant relationship despite ambivalence about exploring their own past. Initial reluctance, therefore, did not necessarily indicate poor engagement or outcome. Rather, parents' expectations, anxieties, and reasons for seeking treatment appeared relevant to how they used the intervention.

More recently, Georg et al. (2021) evaluated a brief four-session focused PIP (fPIP) for infants presenting with Emotional Regulatory Disorders (ERDs). In this RCT (*n* = 154), fPIP was more effective than treatment as usual in reducing regulatory symptoms—particularly night waking—and maternal depressive symptoms. Trends towards increased maternal self-efficacy and reflective functioning were also observed. However, participants were predominantly from relatively low-risk families, limiting the generalisability of the findings to families experiencing greater psychosocial adversity. The study highlighted the potential benefits of early, brief interventions and emphasised the importance of including fathers in future work.

Georg et al.'s (2022) subsequent qualitative study helps illuminate possible mechanisms underlying these quantitative outcomes. Using Grounded Theory to explore mothers' experiences of fPIP, the authors identified seven therapeutic mechanisms, including therapist warmth, rupture and repair, partner involvement, developing alternative perspectives, greater understanding of infant cues, and strengthened maternal identity. These findings suggest that even brief interventions can facilitate meaningful relational change when delivered within a supportive therapeutic frame.

INTEGRATED CRITIQUE AND CONCLUSIONS

There is growing interest in the development of experimental research that evaluates the effectiveness of Parent-Infant Psychotherapy (PIP), owing to longstanding concerns about the limited availability of high-quality outcome studies in psychodynamic interventions more broadly (Barlow et al., 2016). While this expanding evidence base represents an important advance, methodological and conceptual

limitations continue to constrain the strength, interpretability, and generalisability of findings.

Across quantitative studies, recurrent methodological weaknesses include: small sample sizes; lack of intent-to-treat analyses; variable or insufficiently described randomisation procedures; attrition bias; and marked heterogeneity in both participant characteristics and intervention delivery. These difficulties are compounded by wide variation in treatment intensity, outcome measures, and follow-up periods, rendering comparison across studies problematic. Consequently, although RCTs and meta-analyses such as those conducted by Barlow et al. (2016) and Fonagy et al. (2016) provide cautiously encouraging findings, results remain inconclusive and at times contradictory.

Overall, the quantitative literature tentatively suggests that PIP may contribute to improvements in:

- infant attachment security
- maternal representations of the infant
- maternal mental health

However, these effects are neither uniform nor consistently replicated. This variability raises critical questions about for whom PIP is effective, under what conditions, and through which mechanisms. A central limitation of the quantitative literature lies in their limited capacity to capture the complex, relational, and process-oriented nature of PIP. Standardised outcome measures may lack sufficient sensitivity to detect subtle yet clinically meaningful changes in parental meaning-making, emotional containment, or relational organisation, domains central to psychodynamic parent-infant work.

Importantly, null or mixed findings should not be interpreted as evidence of ineffectiveness. Rather, they highlight the constraints of applying conventional methodologies to interventions that aim to influence developmental and relational trajectories rather than discrete symptom reduction. Short follow-up periods—typically extending only to immediate post-treatment to 12 months—are particularly problematic in infancy research, where effects may only emerge gradually. As demonstrated in Salomonsson's work, identifying developmentally appropriate and temporally sensitive outcome measures remains a significant challenge. In addition, the cessation of treatment may itself evoke attachment-related distress, potentially obscuring early post-treatment outcomes.

Another limitation concerns population heterogeneity. Outcomes appear to vary substantially depending on maternal reflective functioning, levels of psychosocial adversity, cultural context, and help-seeking orientation. For example, mothers with higher baseline reflective functioning—often those most likely to engage in PIP—may show limited measurable change on standard instruments, while those with more concrete or idealised representations may demonstrate more visible shifts. These findings underscore the need for more refined participant profiling and theoretically informed subgroup analyses. Salomonsson and Sandell's use of maternal "ideal types" provides one possible model, though such approaches remain underutilised.

Critical gaps also persist across the quantitative literature, including:

- minimal involvement of fathers or partners, despite consistent recognition of their importance.

- limited exploration of prenatal PIP, which may represent a particularly sensitive window for preventative intervention.
- insufficient attention to cultural, racial, and socioeconomic diversity, despite elevated perinatal mental health risk in socially disadvantaged families

Together, these limitations point to the need for methodologically rigorous, yet conceptually flexible research designs capable of accommodating developmental complexity, relational change, and contextual variability.

Qualitative research provides a crucial counterbalance by illuminating how parents experience PIP and how therapeutic change is subjectively understood. Across studies, engagement, perceived usefulness, and outcomes are shown to be shaped by parental expectations, personality style, attachment history, and current psychosocial context, as well as by therapist qualities and the therapeutic alliance.

However, qualitative research in PIP is itself characterised by important gaps. Samples are typically small, demographically narrow, and weighted toward mothers who are already reflective and psychologically minded. Fathers, ethnic minority families, younger parents, and those with more complex relationships to care and authority remain underrepresented. In addition, while qualitative studies richly describe what parents experience as helpful, they less frequently articulate how these experiences translate into sustained developmental change over time. Feeding difficulties remain underexplored, reflecting ongoing conceptual ambiguity across psychopathology, psychiatry and paediatrics.

Despite these limitations, qualitative findings make important contributions. They foreground the centrality of meaning-making; the emotional tolerability of therapeutic

exploration; and the relational fit between parent and intervention. They also suggest that representationally focused approaches may be more beneficial for parents seeking insight and relational understanding, whereas others may require greater structure, guidance, or behavioural support. These insights challenge any assumption of PIP as a uniformly applicable intervention and instead support a pluralistic, needs-led approach that might evolve over time, as illustrated by the pathways between PIP and more focused interventions such as PIFC.

Crucially, both quantitative and qualitative literatures converge on a shared and unresolved issue: limited clarity regarding mechanisms of change in PIP. While improvements in maternal representations, sensitivity, or mood are frequently reported, the pathways linking these changes to infant outcomes remain poorly specified. There is a notable absence of research examining mediating and moderating processes.

Taken together, the literature suggests that PIP is best understood not as a single, by-the-book intervention with uniform effects, but as a relational process whose impact is contingent on context, readiness, and therapeutic fit. Future research would benefit from:

- longitudinal and mixed-methods designs
- closer integration of process and outcome research
- systematic inclusion of diverse family constellations and fathers/partners
- explicit attention to parental expectations and engagement
- greater conceptual clarity about what constitutes PIP across settings and cases

The present study seeks to contribute to this developing field by focusing on a relatively underexplored clinical context—Parent-Infant Psychotherapy for infants with feeding difficulties—and by foregrounding mothers' lived experiences of therapeutic change.

1.4. Feeding difficulties and Parent-Infant Psychotherapy

1.4.1. Feeding difficulties in infancy

Feeding and weaning difficulties—occurring during a developmental phase marked by transition and increasing separation from the primary caregiver—are typically characterised by infant distress, avoidance, or preoccupation with food, often at the expense of other age-appropriate activities and experiences. Such difficulties may be secondary to underlying medical conditions or may arise following distressing medical procedures involving the gastrointestinal system during early infancy. Historically, when feeding problems are not attributable to organic pathology, they have been conceptualised in relational terms, as expressions of disturbances in the mother-infant relationship (Chatoor et al., 1998). In more complex presentations, medical vulnerability and relational difficulty frequently interact bidirectionally, with early physiological challenges amplifying parental anxiety and shaping feeding interactions, while relational stress may in turn intensify infant dysregulation (Chatoor et al., 1998b).

A clinically useful distinction within this literature is between feeding and eating. "Feeding" refers to the relational process through which food is offered and taken within the parent-infant interaction, foregrounding attunement, timing, emotional availability, and co-regulation. "Eating", by contrast, refers more specifically to the infant's autonomous engagement with food. From this perspective, feeding difficulties may be understood as disruptions in the parent-infant relationship, particularly in contexts

where anxiety, control or misinterpretation of infant cues becomes embedded in repeated interactions.

Empirical research has linked maternal stress, depression, and anxiety with less responsive or more controlling feeding styles—including pressuring or under-involved approaches—which are associated with early feeding difficulties. Parents' excessive pressure, control, or restriction may interfere with the infant's emerging capacity to self-regulate intake and disrupt responsiveness to internal cues of hunger and satiety. Over time, this may contribute to cycles of food refusal, infant distress, and heightened parental anxiety (Birch & Davison, 2001; Calvioni & Galimberti, 2008; Stein et al., 2001).

Early feeding difficulties are commonly conceptualised as part of broader regulatory disorders, alongside problems with crying, sleeping, and sensory processing. Epidemiological studies suggest that regulatory difficulties affect a substantial minority—estimated at approximately one in ten—although prevalence rates vary depending on definitions and assessment methods (Briggs-Gowan et al., 2006; Georg et al., 2021; Skovgaard et al., 2007). It remains unclear whether feeding problems in infancy constitute developmental precursors of later eating disorders or reflect distinct pathways with different mechanisms and outcomes. This uncertainty underscores the need for longitudinal research capable of distinguishing developmental trajectories and identifying which infants are most at risk of persistent difficulties (McDermott et al., 2010).

Taken together, the literature conceptualises feeding difficulties in infancy as multifactorial and relational phenomena, shaped by the interaction of infant

vulnerability, parental mental health, early medical experiences, and patterns of parent-infant co-regulation. This body of work provides a rationale for relationship-based interventions, such as parent-infant psychotherapy, which aim to address feeding difficulties not as behavioural symptoms, but as expressions of the developing parent-infant relationship within a broader emotional and developmental context.

1.4.2. PARENT-INFANT FEEDING CLINIC (PIFC)

The Parent-Infant Feeding Clinic (PIFC) is a specialist adaptation of Parent-Infant Psychotherapy (PIP) designed to address feeding difficulties in children under the age of three, a developmental period in which feeding remains largely regulated, structured, and mediated by parents. It was developed in response to a clinical need identified within a Perinatal Parent-Infant Mental Health Service (PPIMHS) and is grounded in the premise that early feeding difficulties frequently reflect underlying disturbances in the parent-infant relationship.

Referrals to the PIFC follow the same pathway as other PPIMHS referrals; however, a key distinction lies in the nature of the presenting concern. Whereas traditional PIP referrals are typically driven by parental mental health difficulties or relational concerns, PIFC referrals centre on the infant's feeding difficulties. Clinical work within the PIFC often reveals that feeding difficulties are embedded within broader relational patterns, with therapeutic attention gradually shifting from symptom-focused concerns to the parent-infant relationship.

Historically, the PIFC has received referrals for premature infants and for families in which parents experience low mood, anxiety, or avoidant coping styles, whether these difficulties preceded the feeding problem or emerged in response to it. Families referred to the clinic are heterogeneous in background and composition. Assessment

considers the infant's weight, behaviour, birth history, and developmental profile. Common referral narratives include prematurity, early medical intervention, difficulties with breastfeeding, and challenges during the transition to solid foods. These presentations are often accompanied by high levels of parental anxiety and confusion, sometimes imbued with an urgent or catastrophic emotional tone. Within this context, infants may appear unable to "take anything in", both concretely and relationally, with implications for the developing parent-infant bond.

The PIFC is explicitly research-oriented: sessions are video-recorded, coded, and analysed, and outcome data are routinely collected.

Triadic Emotional Approach (TEA)[1]

The clinical intervention at the core of the PIFC is the *Triadic Emotional Approach (TEA)*, developed by the clinic lead and senior Child and Adolescent Psychotherapist within PPIMHS. TEA introduces a triangulated dynamic into feeding interactions, operationalised through structured symbolic play. The central task involves a pretend tea party enacted between the psychotherapist, the infant, and the parent(s).

Sessions take place on the floor, with a tea set placed between three cushions (or four when a partner/family member is present), alongside dolls to support play. Parents are invited to participate in the play but are initially instructed not to respond to the infant, allowing the infant to choose whether and when to enter the interaction. The therapist initiates the play, often beginning with the invitation, "Would you like some tea?", and symbolically offers food to the parent by holding it close to the mouth or face. This

[1] TEA was developed by Silvina Diaz-Bonino (silvina.diazbonino@gmail.com) and is currently in preparation for publication.

intimate gesture is discussed beforehand to ensure that it is understood and tolerated, since it may evoke discomfort, shame, or anxiety.

Parents vary in their capacity to imagine and engage in symbolic play, which offers salient information about their mental state and relational functioning. The infant is not directed to participate but is expected to bring themselves into the triangular space over time. Early sessions may feel counterintuitive and provoke anxiety or resistance, particularly when exclusion or waiting activates fears of abandonment or rivalry. The therapist offers reflections on the infant's possible experience and on emerging relational dynamics, making unconscious processes more accessible to the parent.

Aims

The intervention aims to reorient development where feeding relationships have become disrupted, supporting the infant's movement toward age-appropriate relational and symbolic capacities. Change is tracked using the *Infant Receptivity Scale* (Diaz-Bonino & Spencer, 2017), which assesses the infant's receptivity within dyadic and triadic interactions and their capacity for pre-symbolic and symbolic play.

Infants often become dysregulated during sessions, particularly in response to the intensity of triangulated interaction. Sessions may be paused to allow for re-regulation, modelling containment and repair. Sessions last 45-50 minutes, during which the game is repeated several times to explore the details and observe change or progress. Initially, many infants struggle to tolerate the triangular configuration, seeking refuge or disengaging through sleep or withdrawal, so as to self-regulate and maintain emotional equilibrium. Over time, repeated exposure can increase tolerance of emotional arousal and triangulation. Gradually, infants may begin to imitate the

parent's role and enter the third position with curiosity, signalling emerging symbolic capacity and relational differentiation.

In some cases, infants develop the capacity to feed before parents become fully aware of the relational meanings underpinning the difficulty. With premature infants, feeding problems may be linked to unresolved experiences of early medical care, including NICU admissions and tube feeding. These infants may require reassurance and may temporarily regress to earlier states of mind (marked by heightened survival anxiety) as part of a broader process of emotional integration.

Structure, duration, and assessment

Typically, a non-intensive intervention lasts around eight to twelve weeks. The frequency of sessions may increase depending on the intensity of the child's needs. In cases of infantile anorexia, a more intensive treatment plan may be required and can be safely carried out in the community. During the first four weeks of the treatment plan, all food and drink in the play are imaginary. From the fourth week onward, small edible items and fluids may be incorporated into the game, if appropriate. Home videos of family mealtimes are used to observe feeding interactions in naturalistic settings and are discussed within sessions.

Parents are expected to commit to regular attendance, provide home videos, and consent to session recordings. Early improvements are often anticipated by sessions four to five; by eight to twelve sessions, many infants are expected to show increased independent feeding. Where progress is limited, further assessment may indicate more pervasive developmental or relational difficulties. Following 8-18 weeks, and where Infant Receptivity scores indicate sufficient progress, families may transition into a more traditional PIP framework.

Initial assessment focuses on parents' understanding of the problem, their expectations of help, and the emotional meanings associated with feeding. Feelings "served with the food"—including anxiety, frustration, guilt, and grief—are explored alongside parental perceptions of infant feeding difficulties and negotiations around dependence and autonomy. Practical considerations, such as the infant's developmental readiness for solids, are also assessed.

Psychoanalytic formulation

The PIFC is informed by both child development research and psychoanalytic theory. From a psychoanalytic perspective, feeding difficulties may emerge when containment within the early parent-infant relationship breaks down, giving rise to persecutory anxiety within the infant's internal world, understood in terms of unconscious phantasies. Drawing on Winnicott's (1955, 1988) work, feeding disturbances may disrupt the infant's capacity to experience feeding as a pleasurable, spontaneous, and uninhibited activity. Winnicott descried early feeding as necessarily "ruthless", in the sense that the infant must be able to take in the object without concern for its survival. This capacity supports the expression of ordinary oral aggression and forms a crucial foundation for later concern and reparation.

When early experiences of pain, distress, or invasive medical intervention become associated with oral excitement, feeding may come to be experienced as dangerous rather than pleasurable. In such circumstances, excited feeding or biting is inhibited, compromising the infant's capacity to express ordinary oral aggression. Food may then acquire aggressive and persecutory qualities, no longer alleviating hunger but instead being experienced as a threat to bodily integrity, leading to refusal as a defensive survival response. This formulation is consistent with Winnicott's (1988) premise that

the infant's psyche develops through a partnership with the body and its functioning. When bodily experiences become saturated with anxiety or pain, this partnership may be compromised, with implications for emotional integration and development.

Psychodynamic accounts further conceptualise severe feeding refusal as reflecting anxieties about dependency and "taking in" relationships. Williams' notion of a "no-entry system", informed by Bion's work on containment, has been used clinically to describe defensive refusal aimed at protecting the infant from overwhelming or persecutory experience (Bion, 1962, 1989; Williams, 1997). In this formulation, food is experienced as a hostile or inimical foreign body, something feared as invasive and overwhelming, thereby impeding processes of individuation. Refusal functions defensively, by blocking access to what is experienced as indigestible, both concretely and psychically.

In such contexts, maternal anxiety may be transmitted to the infant rather than transformed. Instead of Bion's (1962) alpha function, which enables emotional experience to be metabolised and made thinkable, relational patterns may become disorganising, reflecting what Williams (1997) describes as Omega function, in which emotional experience overwhelms the infant rather than contains. The result may be a severely impaired capacity to make sense of emotional experience. These defensive organisations are often highly omnipotent and controlling, functioning to shield the infant from experiences of loss, helplessness, and dependency that are developmentally salient during weaning (when the infant begins to ingest solids).

Clinically, these dynamics may manifest in what appears as tyrannical infant behaviour, particularly directed toward the mother. In response to experiences of despair, anxiety, or painful rejection, the mother may feel compelled to meet all the

infant's demands in an attempt to restore equilibrium within the relationship. Conversely, when the infant can feed, this may significantly bolster the mother's confidence in the value and adequacy of what she has to offer, both physically and emotionally, reinforcing a more secure sense of maternal competence.

The PIFC also attends to maternal states of withdrawal or *"psychic retreat"* (Steiner, 1993), in which anxiety, guilt, or unresolved trauma constrain the parent's capacity to engage with reality and infant's developing separateness. Such retreats may serve as a defensive function for the parent but can limit emotional availability and impede relational development.

Through play, observation, and shared reflection, the intervention seeks to re-engage the parent emotionally and to facilitate movement from a predominantly dyadic organisation toward a more differentiated, triadic relational space. The presence of a third position—conceptualised psychoanalytically as a paternal function (Britton, 1989)—is understood as essential for supporting separation, triangulation, and symbolic development. In this context, the PIFC intervention may activate unconscious oedipal constellations within the family that have remained unresolved, particularly where the dyadic relationship has become entrenched.

Within this process, the therapist may experience intense transference and countertransference states, at times feeling like a persecutory intruder subjecting the infant to something akin to torture, or alternatively feeling excluded, ignored, or rendered irrelevant. Feelings of competition, helplessness, dread, or anxiety may arise and are understood as clinically meaningful indicators of the infant's and parent's subjective experiences of feeding and thirdness. Over time, and where containment can be restored, moments of pleasure and curiosity may begin to emerge, often

alongside significant ambivalence and suspicion, signalling the tentative reintroduction of trust and relational openness.

Outcome measures

Outcome evaluation within the PIFC includes the Infant Receptivity Scale, measures of Parental Embodied Mentalisation (PEM), infant weight before and after intervention, and structured parental feedback. Together, these measures aim to capture change across behavioural, relational, and representational domains.

CHAPTER 2. METHODOLOGY

2.1. RATIONALE

2.1.1. RESEARCH QUESTION

As outlined in the Introduction, the starting point for this research emerged from a personal interest in understanding how Parent-Infant Psychotherapy (PIP) operates. While I recognize the importance of quantitative research in addressing questions of effectiveness, my primary interest lay in what parents themselves have to say about their experiences and how they make sense of them—an orientation consistent with the aims of qualitative research. Initially, my focus was broad: to explore parents' experiences of PIP with the aim of informing clinical practice and contributing to theoretical understanding.

However, I came to recognise that, to examine abstract concepts in a way that could be meaningfully explored and articulated, a more focused research question was required. This led to narrowing the scope of the inquiry to parents' experiences of change in Parent-Infant Psychotherapy when their infants presented with feeding difficulties. The research question thus evolved from a general exploration of experience to a more specific focus.

I expected that inviting parents to reflect on "change" might facilitate deeper consideration of how PIP had worked for them and in what ways. This focus also supported the development of a more structured interview schedule. At the same time, I became aware that, consciously or unconsciously, I may have been seeking evidence of effectiveness. Yet "change" is neither singular nor self-evident and can be understood in multiple ways depending on how it is defined. As I began interviewing participants, I noticed that similar questions often elicited both convergent and

divergent responses. This prompted further reflection: does something have to change for therapy to be meaningful? Is there an implicit idealisation or expectation that therapy should lead to a "cure"?

These reflections raised ethical and philosophical questions about the nature of change: how it is understood, how much it matters, and whether my research aimed to generate theory or test hypotheses. I came to see that it involved elements of both. I also reflected on how psychoanalytic thinking often privileges growth, development, transformation of emotional states, and shifts in understanding over discrete or measurable change. Consequently, this project adopted an openness to both change and non-change when exploring parents' experiences of PIP.

Ultimately, immersing myself in the research question proved to be an enriching and thought-provoking process. Allowing myself not to know what might emerge became a valuable part of the journey. I have come to appreciate how research challenges desires for certainty and control, and how becoming a researcher involves navigating loss as well as gain, learning to hold both throughout the process.

2.1.2. SETTING

This research project took place within the Parent Infant Feeding Clinic (PIFC), a specialist pathway situated within the Perinatal Parent-Infant Mental Health Services (PPIMHS) in a large suburban area in the NHS. The PIFC was established by my supervisor, who worked alongside another child and adolescent psychotherapist trainee.

Prior to formally developing my research question, I approached my supervisor to express my interest in conducting my doctoral research within the PPIMHS service. I was advised to recruit parents from the PIFC. This recommendation reflected both the

clinical relevance of the PIFC to my research interest and pragmatic considerations, as my supervisor's direct involvement meant that recruitment could be more effectively supported. In contrast, I did not have regular contact with the broader PPIMHS team, which would have made recruitment from other PIP pathways more complex. Given the small scale of my project, I accepted the practical necessity of recruiting participants already connected to PIFC, where parents had also already consented to participate in research.

At the time of the study, I was working within PPIMHS as a trainee child and adolescent psychotherapist but did not work clinically within the PIFC, where my role was solely that of a researcher for over two years.

Parents accessing the PIFC were referred by their GP, midwife, health visitor, or other clinicians within PPIMHS already involved with the family, when concerns arose regarding weaning or feeding difficulties that could not be explained by medical causes. Many of the mothers and infants referred to the clinic had experienced trauma during the perinatal period. In several cases, infants had spent time in Neonatal Intensive Care Units (NICU), often requiring nasogastric tube feeding.

In addition to direct referrals, my supervisor facilitated a twice-monthly PIFC consultation group for professionals within and outside PPIMHS who had concerns about feeding difficulties in infants they were supporting. The group offered a space for considering the appropriateness of referral to the PIFC.

As part of routine clinical practice, parents and infants referred to the PIFC were assessed and informed that the clinic operates as a research-based service. Consent to participate in research activities—such as taking part in additional studies—was

formally obtained and documented during the assessment process within clinical systems.

For the purposes of this study, the PIFC is conceptualised as a form of parent-infant psychotherapy (PIP). However, it differs from traditional PIP models in both structure and focus, having been specifically adapted to address feeding-related difficulties within the parent-infant relationship.

2.1.3. Why Interpretative Phenomenological Analysis (IPA)?

IPA is a qualitative research approach concerned with exploring how people make sense of and reflect upon their lived experiences. It aims to produce a consistent, sophisticated, and nuanced qualitative analysis while remaining open to complexity, embracing difference, and encouraging dialogue with other disciplines (Smith, Flowers, & Larkin, 2009).

I found the underlying epistemology of IPA particularly compelling. As a phenomenological approach, IPA focuses on how individuals make sense of personally meaningful experiences, often facilitating self-reflection, symbolic thinking, and meta-awareness. It recognises that meaning is shaped by the prior experiences, internal worlds, and personality of individuals, offering a mature, multifaceted and holistic form of phenomenological inquiry.

A central feature of IPA is its interpretative double hermeneutic: the researcher seeks to make sense of the participant, who is making sense of their own experience. This “second-order sense-making” (Smith & Osborn, 2003) positions the researcher as both empathic listener and an active interpreter.

Importantly, IPA is idiographic in orientation, focusing on detailed examinations of the particular case. This involves in-depth analysis of how individual experiential phenomena—such as events, processes, or relationships—are understood from the participant's perspective and situated within specific cultural, racial, and socioeconomic contexts. Each participant therefore offers a uniquely personal account of the phenomena under investigation.

IPA typically draws on small, purposively selected, and carefully situated examples. Rather than seeking statistical generalisation, it aims for theoretical and experiential transferability – the possibility that insights from one case may resonate with others in similar contexts (Smith et al., 2009). Through this approach, IPA attends to both shared and divergent aspects of experience across a small number of participants.

IPA is experiential rather than experimental and offers a valuable counterpoint to dominant quantitative approaches. It allows for a form of "binocular vision" – a term introduced by Bion (1970), through which multiple perspectives can be held simultaneously.

IPA employs analytic induction, beginning with tentative interpretative propositions that are iteratively tested and refined through close engagement with each case (Smith et al., 2009). This process encourages openness to emerging meanings and aims to articulate experience in its own terms rather than through predefined categories.

Participants often engage with what IPA terms "hot cognition" – emotionally charged, ambiguous experiences that are not fully accessible in a purely objective enquiry (Smith et al., 2009). IPA therefore prioritises experience-close research, seeking to remain faithful to participants' meaning-making while explicitly acknowledging the interpretative role of the researcher.

IPA adopts a pluralistic orientation, valuing its underlying philosophical commitments over rigid procedural adherence. It shares clear affinities with psychoanalytic thinking through its attention to latent or implicit meanings in narrative material and its emphasis on depth, interpretation, and complexity. This made IPA a particularly appropriate methodological fit for my psychoanalytic orientation, as both approaches are centrally concerned with meaning-making and lived experience (Larkin & Thompson, 2011; Rustin, 2007, 2015). In this sense, the researcher's reflective engagement with the material—akin to the psychoanalytic stance of observing both participants and one's own responses to them—is understood as contributing to, rather than undermining, understanding.

At the same time, IPA is not without its tensions. Discrepancy often arises between the methodological ideals and research practice. While IPA aims to capture the richness of lived experience, interpretation inevitably shapes the analysis, rendering it inherently subjective. Its reliance on small, relatively homogenous samples prioritises depth over breadth and limits generalisability. Researchers may also struggle to balance fidelity to participants' accounts with the need to produce a coherent and analytically meaningful interpretation. Finally, IPA's intensive and iterative approach can be time-consuming and emotionally demanding, particularly when working with sensitive material. These tensions highlight the ongoing negotiation between methodological aspiration and practical constraint.

2.2. Research design

2.2.1. Recruitment

Following discussions with my clinical supervisor at PPIMHS, we agreed that recruiting parents through the PIFC would be most viable—given its research-oriented structure

and existing governance approvals—with managerial agreement obtained as part of this process. My supervisor and I worked collaboratively to refine the research question and to develop the ethical approval process.

Within PPIMHS, a multidisciplinary research group met monthly to support research development. I presented my project to this group and subsequently to the wider PPIMHS team to ensure transparency and awareness across the service, regardless of clinicians' direct involvement in recruitment.

I then met with the PIFC team to discuss recruitment from the clinic. A participant information sheet outlining the study (Appendix C) was circulated, and it was agreed that clinicians could inform parents about the study once an ending date had been agreed or the case had recently concluded, provided research consent was already documented. Clinicians sought parents' permission for me to contact them if they expressed interest.

I aimed to recruit four parents who had attended a minimum of six PIFC sessions. There was no upper limit on the number of sessions, provided clinicians felt participation was appropriate. The sole exclusion criterion was insufficient English proficiency to participate in an interview.

Several meetings were required to identify potential participants. While clinicians were generally supportive, some apprehension was evident. Comments such as "this mother would be very good at being interviewed" suggested that clinicians were making assumptions about suitability, often favouring parents with whom they had formed positive relationships and whom they perceived as better able to engage. This raised questions about how clinicians' protective instincts and presuppositions regarding benefit or compliance may have shaped recruitment.

Some clinicians framed participation as an opportunity to “give feedback”, which may have felt less threatening than speaking directly about therapy and may have influenced parents’ perceptions of the study. I was mindful of building trust with clinicians independently of the context of my relationship with my supervisor while avoiding any sense of pressure, particularly given the sensitive nature of the work and clinical demands.

Four out of five invited participants—all mothers—ultimately took part. Recruitment extended over a prolonged period: two interviews were conducted in December 2023, one in August 2024, and the final interview in February 2025.

Participants were referred by clinicians within the PIFC team, including my clinical supervisor, a trainee Child and Adolescent Psychotherapist, and a senior Parent-Infant Psychotherapist. I contacted potential participants by telephone to explain the study, emphasising the voluntary nature of participation and the value of hearing about their experience of change within PIFC. Four mothers expressed interest at initial contact. One requested to be contacted again after two months due to work commitments; she later agreed to receive further information and to schedule an interview but subsequently disengaged.

Participants were emailed an information sheet and consent form (Appendices C & D) along with suggested interview dates. Two interviews were conducted in person and two online. Although in-person interviews were preferred, this was not feasible for all participants. Video interviews were therefore conducted, consistent with qualitative research evidence supporting their use (Archibald et al., 2019).

Prior to interviews, I contacted participants to establish rapport and address any concerns. One mother expressed ambivalence, asking “Do I really have to do this?” I

reassured her that participation was entirely voluntary and confidential, after which she chose to proceed.

No fathers were referred for participation. This reflects a persistent gap identified in the literature: despite strong advocacy for fathers or partners' involvement in PIP, they remain underrepresented in practice. Consequently, the findings reflect exclusively maternal perspectives.

2.2.2. Participants

The sample size was small, consistent with the idiographic focus of qualitative research and IPA. Participants were purposefully selected. Background information is provided to contextualise the findings, while preserving anonymity. All names of participants and psychotherapists have been changed, and participants are presented in the order in which interviews took place; this ordering does not imply hierarchy or significance.

All participants were mothers. Three of the infants were boys and one was a girl.

Sana and Abdul (P1)

Sana, a woman in her thirties, attended the interview in person with her baby daughter, who had not participated in PIFC sessions. Sana had previously engaged in PIP and subsequently attended weekly PIFC with her older son—who was three years old at the time and presented with significant food selectivity—for less than a year. She identified as Asian British, Muslim, and was a working professional.

Priya and Aryan (P2)

Priya, a mother in her early forties, attended weekly PIFC with her youngest son, Aryan, aged three, for less than a year due to concerns that he was not eating. She also had older children. Aryan was present during the interview due to a lack of

childcare. Priya was an Asian immigrant living in the UK and was not in paid employment at the time of the interview. Although she had not required an interpreter during therapy, her clinician recommended that one be available for the interview if needed. The interview was conducted in person.

Paula (non-participant)

Paula was the only mother who disengaged from the research project. She was a White South European woman in her mid-thirties and a working professional. Although she initially agreed to participate, she did not attend the scheduled interview and subsequently disengaged from the study.

Lia and Ibi (P3)

Lia, a woman in her forties, attended the interview online without her children present. Her baby daughter, Ibi, had attended weekly PIFC from six months of age for approximately one year, having presented with refusal of solid food during the transition to weaning. Lia also had older children. She identified as White British and was a working professional. Prior to referral to the PIFC, Lia had received long-term PIP support during pregnancy and with Ibi, in total for around a year.

Marcia and Musa (P4)

Marcia, a woman in her late thirties, attended the interview online. She had previously participated in weekly PIFC approximately ten years earlier for less than a year, when her first son, Musa, was around eight months old and presented with refusal of solid foods during the transition to weaning. At the time of the interview, she was receiving PIP support with her younger son. Marcia identified as Black British and was a working professional.

Notably, three participants had previously engaged in PIP with other clinicians or were undertaking PIP with another infant at the time of recruitment. In these cases, entry into PIFC followed prior engagement with PIP within the wider PPIMHS, focused primarily on maternal mental health and the mother-infant relationship. Referrals to the PIFC were initiated by the PIP therapist, where feeding and weaning difficulties were emerging or persisting and were recognised as requiring a more targeted intervention. This pathway reflects continuity of care rather than therapeutic failure, with the PIFC functioning as a specialist extension within an existing care pathway.

In contrast, one participant was referred directly to the PIFC by a health visitor, highlighting an alternative route of access and variability in how families entered the service. These differing referral pathways were considered analytically relevant, as they contributed to heterogeneity in participants' prior therapeutic experiences and expectations of the intervention.

The sample reflected diversity in maternal backgrounds, which is important for understanding how experiences of crisis, help-seeking, and access to support may be shaped by social, cultural, and systemic contexts, including variations in routes into services.

2.2.3. Data collection: interviews

Interviews were selected as the primary method of data collection, as they were expected to foster interactivity and elicit in-depth, context-rich accounts of perceptions and perspectives (Bloomberg & Volpe, 2023). Interviews are particularly well suited to exploring complex relational processes and facilitating open discussion, allowing nuance to emerge.

I used semi-structured interviews alongside a field diary in which I recorded reflections throughout the interview process. Consistent with a phenomenological approach, the field diary enabled attention to the dynamics of the interview setting, including moments of countertransference and the presence of children, and to how meaning was co-constructed in situ (Morrel-Scott, 2018).

In line with IPA, interview questions were designed to be open-ended and as free as possible from implicit assumptions or researcher bias (Pietkiewicz & Smith, 2012). The interview scheduled (Appendix E), developed in consultation with my research and PPIMHS supervisors, provided prompts to guide discussion while allowing participants to lead the narrative. Although the schedule offered structure and confidence in my role as a novice research interviewer, I sometimes experienced it as constraining and felt pressure to adhere to it too rigidly.

Drawing on clinical listening skills, I aimed to avoid assuming the role of the “primary expert” and remained attentive to transference and countertransference dynamics that can emerge. While semi-structured interviews allow flexibility and depth, they can also carry the risk of the researcher inadvertently shaping the data through interruptions or leading responses. Reflexivity was therefore central to my approach. On reviewing recordings, I became aware that I occasionally interrupted participants or slipped into a more clinical stance by validating or reflecting participants’ experiences, highlighting the ongoing challenge of negotiating the boundary between clinician and researcher.

The interval between termination of PIFC sessions and interviews varied considerably. For three participants (Sana, Priya and Lia), interviews took place approximately two weeks after the end of treatment, while for Marcia, around ten years had elapsed since

PIFC involvement. It is likely that this temporal distance influenced how experiences were remembered, reflected upon, and narrated.

Interviews were planned to last up to one hour. In practice, three interviews lasted approximately 75 minutes, while one concluded within 60 minutes. I had the sense that participating in the interview allowed mothers to position themselves, at least momentarily, outside their role as patients, offering a degree of distance and perspective. Prior to each interview, participants signed consent forms and were reminded that there were no right or wrong answers. Confidentiality was emphasised throughout.

The presence of children during several interviews shaped the interview context. I found myself attending to children's comfort and safety while also observing how they communicated indirectly through play, interruptions, and emotional expression. This highlighted the difficulty some participants might have experienced in separating from the parent-infant dynamic and raised questions about how maternal identity influenced both their narratives and capacity for reflection.

As interviews progressed, participants' assumptions about what could or should be said became apparent. One participant remarked that "*nobody wants to hear about the negative things*", which alerted me to the need to explicitly invite discussion of difficulties, disappointments, and aspects of the intervention that had not worked. These conversations were often emotionally charged and challenging; the same participant described how hard it was "*to relive all the horrible parts*". I felt a strong sense of responsibility to ensure that participants felt heard and valued, particularly given the broader service context, where some mothers were approaching discharge while others remained engaged with services through work with another child. The

proximity of interviews to therapeutic ending, or their overlap with ongoing care, appeared to shape these dynamics.

At the end of each interview, participants were offered the opportunity to contact me for debriefing, and a debrief form was subsequently sent (Appendix F). None of the participants took up this offer.

All interviews were audio-recorded and transcribed verbatim by me shortly after completion. Recordings were deleted following transcription, in accordance with the consent agreement.

Practical arrangements varied. The two in-person interviews proceeded as planned, with each mother bringing one child; one was conducted with the support of a female interpreter. The two online interviews were more complex. One mother participated from home while her partner cared for the children, while the other joined from her car while her baby slept, occasionally needing to drive gently to maintain the infant's sleep.

Each of the mothers interviewed online initially missed scheduled appointments but later re-established contact, apologised, and expressed a strong wish to participate. This highlighted how emotionally and practically demanding participation can be and drew attention to the emotional labour involved for the researcher when working with vulnerable populations.

One participant ultimately disengaged, expressing uncertainty about whether she had enough to share and indicating limited capacity to commit time. This raised important questions about readiness, timing, and the ethical limits of participation. It prompted further reflection on the challenges of inviting participants to revisit experiences that

may be traumatic or only partially processed, particularly in the absence of the containment offered by therapeutic settings.

Across interviews, participation itself appeared to be experienced as meaningful and, at times, demanding. Several mothers were motivated by a wish to be helpful—to contribute to service development, support other mothers, or give something back to a service they valued. At the same time, participants negotiated boundaries around how much they could tolerate discussing difficulties, both practically and emotionally.

2.2.4. DATA ANALYSIS

Data analysis commenced once all interviews had been completed, and the full dataset was available. The analytic process followed the stages outlined in IPA (Smith et al., 2009).

Step 1. Reading the text

The first stage involved transcribing the audio-recordings verbatim. I listened to each recording twice: initially while producing the transcript, and again while reading through the text to ensure accuracy and deepen familiarity. Each transcript was read multiple times to achieve immersion in the material. At this stage, I avoided interpretation, focusing instead on becoming closely acquainted with participants' accounts.

Allowing time to elapse between interviews and subsequent readings proved valuable, enabling me to approach the data with greater reflexive distance. Although transcription was time-consuming, it was central to maintaining proximity to the data and supporting in-depth engagement with participants' experiences (Smith, Flowers, & Larkin, 2022)

Step 2. Exploratory noting

I next engaged in detailed exploratory noting (Appendix G), attending to both semantic content and language use while maintaining an open and curious stance. Each transcript was reread at least twice to generate a rich set of notes. Attention was paid to participants' choice of language and the context of their comments, allowing initial interpretative insights to emerge (Smith et al., 2022).

Exploratory notes were recorded in the left margins and took three forms:

- Descriptive notes, focusing on what was said
- Linguistic notes, attending to tone, laughter, pauses, repetition, emotion words, and metaphors
- Conceptual notes, involving reflective questioning, tentative interpretation, and reflexive observations

Salient passages were highlighted, and reflections from my field diary were integrated into this stage of analysis.

Step 3. Constructing experiential statements (ES)

At this stage, I aimed to reduce the volume of detail while retaining experiential complexity. Drawing primarily on the exploratory notes, I developed experiential statements that captured participants' lived experience and their meaning-making processes. This required balancing close engagement with the data and a modest level of conceptual abstraction.

To monitor interpretative drift, I ensured the transcript data remained central. I initially found it challenging to move beyond descriptive summarisation, which led me to revisit

transcripts multiple times to refine ES. These were recorded in the right-hand margin of each transcript (Appendix G).

Step 4. Searching for connections across experiential statements

Through the use of mapping and clustering, I then examined how experiential statements (ES) related to one another. Only statements that clearly addressed the research question were retained. This process required frequent movement between transcripts, exploratory notes and ES, in this way moving in the hermeneutic circle, the iterative dialogue between parts and whole.

To support this process, ES were labelled with page and line numbers to maintain traceability. Conceptual groupings were explored by treating each statement as equally significant until a coherent structure emerged. Clustering was informed by abstraction, polarisation, and frequency within individual accounts.

Step 5. Naming personal experiential themes (PETs)

Each cluster of experiential statements was assigned a title capturing its defining characteristics, forming personal experiential themes (PETs). These were organised into a table for clarity and analytic overview (Appendix H).

Step 6. Repeating the process across cases

Steps 1 to 5 were repeated for each of the remaining participants, allowing each case to be analysed on its own terms before moving to cross-case comparison.

Step 7. Developing group experiential themes (GETS)

The final stage involved cross-case analysis, examining patterns of convergence and divergence across participants' PETs. This process led to the development of group

experiential themes (GETs), capturing shared and distinct aspects of experience across the sample (Appendix I).

2.3. Ethics

Full ethical approval for this study was obtained from the Tavistock Research Ethics Committee (TREC) (Appendix J). Participants were informed that their participation was entirely voluntary and that they could withdraw at any time without consequence.

All identifying information was removed to protect participant anonymity. However, given the small sample size and the specialist nature of PIFC, complete anonymisation was not possible. Issues of confidentiality were therefore discussed carefully, both in verbally and in writing, and informed consent was obtained from all participants prior to participation.

Participants were approached by their therapist once they were nearing the end of their PIFC intervention, and an ending date had been agreed. It remains difficult to determine how the timing of the interviews in relation to the therapeutic ending may have influenced participants' responses. Although efforts were made to minimise power dynamics, these may nonetheless have been present. Notably, two clinicians expressed relief that interviews were conducted soon after therapy ended, suggesting this timing might offer “some space” and help mitigate feelings of being “dropped” following discharge.

At the time of the interviews, participants remained open on the PPIMHS caseload, with the service retaining responsibility for their care. During interviews, participants often expressed strong appreciation for clinicians and the service, alongside a reluctance to voice dissatisfaction or conflict. Several mothers also articulated a wish

to support the visibility and funding of PPIMHS, which may have further influenced their motivation to participate.

All data were recorded, stored, and managed in anonymised and encrypted formats in line with data protection requirements. Some interviews were conducted via Zoom, in accordance with approvals granted through the relevant research governance processes.

Throughout the study, I reflected carefully on issues of cultural sensitivity. This included considerations of translation, transcription, and the adaptation of methods in culturally meaningful and contextually appropriate ways. I was attentive to how language, context, and setting could shape how experiences were conveyed and understood, and to whether the research upheld cultural integrity by respecting participants' backgrounds, lived experiences, and worldviews. This had the further aim of reducing the risk of misinterpretation.

Furthermore, prior to the interview involving an interpreter, I met with the interpreter to explain the importance of maintaining accuracy and neutrality in translation. Her role was clarified as translating the participant's words as faithfully as possible, without excessive interpretation or altering meaning. Nevertheless, working through an interpreter introduced additional complexity. The interview process was necessarily slower, as each question required translation before the participant could respond, followed by translation of her response. This also altered the conversational flow and, at times, appeared to limit the depth and spontaneity of exploration. It was difficult to determine whether this reflected the process of interpretation, the participant's capacity or readiness for reflection, or an interaction between these factors. I also remained mindful of the emotional impact of the material on the interpreter, who was herself an

active presence within the interview encounter. These factors were considered reflexively when interpreting the participant's account.

2.4. Researcher's reflexivity

The use of IPA explicitly acknowledges the active role of the researcher in the research process. As an immigrant living in the UK, I was aware of the cross-cultural dimensions inherent in this study. One participant was an immigrant, two were second-generation mothers from minority ethnic backgrounds, and one was White British. These intersections foregrounded broader sociocultural and political contexts that may have shaped participants' experiences of motherhood and their engagement with services.

Throughout the research process, I reflected on the cultural credibility of my findings, considering not only methodologically robustness but also their cultural meaningfulness to participants. This required sustained reflexivity and recognition that my positionality, assumptions, and interpretative lens inevitably shaped how I conducted interviews, related to participants and the service, and analysed the data. While I aimed for rigour and transparency, I acknowledged that qualitative research is inherently subjective. Rather than attempting to eliminate this subjectivity, I sought to make it explicit and accountable.

My receptivity as an interviewer—how I listened, asked, and interpreted—was influenced by my positionality, and I remained open and self-critical throughout the research process. Traditional notions of reliability and replicability are less applicable to IPA. Instead, I focused on dependability by clearly documenting analytic decisions and methodological steps, enabling others to follow the interpretative logic underpinning the findings.

Although formal triangulation methods were not feasible due to the project's scale and time constraints, other strategies were employed to enhance trustworthiness. I engaged in regular individual supervision with my research supervisor throughout all stages of the project. In addition, I participated in group research supervision sessions where aspects of data collection and emerging themes were discussed. These forums provided peer and academic scrutiny and horizontal support (Mersky, 2018), offering opportunities for challenge, validation, and alternative perspectives, and contributing to the overall rigour of the analysis.

As a psychoanalytic child psychotherapist, I am accustomed to attending to unconscious processes, including my own responses and biases. Clinical training emphasises the use of countertransference and ongoing personal analysis, which can be an asset in qualitative research where the researcher is deeply engaged with the data. However, I remained mindful that clinical and research encounters differ fundamentally. In therapy, countertransference is used in service of the client; in research, the aim is to explore participants' experiences without imposing interpretative frameworks prematurely. I therefore sought to bracket my therapeutic instincts during data analysis, staying as close as possible to participants' language and meanings.

2.5. LIMITATIONS

Given the small scale and time constraints of the project, formal triangulation methods (such as focus groups, surveys, or multiple independent analysts) were not feasible. This limits the trustworthiness of the findings, particularly in relation to credibility, confirmability, dependability, and transferability. Although interviews generated rich and detailed accounts, interpretations could not be corroborated through alternative data sources.

A further limitation relates to data saturation. While key themes emerged with clarity, the small sample size and restricted analytic timeframe mean that full thematic saturation may not have been achieved. Additional interviews or complementary methods may have yielded further nuance or perspectives not captured in this study.

CHAPTER 3. FINDINGS

This chapter presents the findings from the Interpretative Phenomenological Analysis, organised into Group Experiential Themes (GETs) (Appendix I) that capture how mothers experienced change through engagement with Parent-Infant Psychotherapy within a specialist Parent-Infant Feeding Clinic (PIFC). These themes trace mothers' experiences of entering the service, changes in their infants, shifts within themselves, transformations in the mother-infant relationship, the reorganisation of feeding, and the relational and systemic conditions shaping engagement over time.

A. What led to PIFC

This theme captures the pre-change context in which mothers and infants encountered PIFC. It illuminates how mothers experienced themselves, their infants, and their relationships at the point of entry, and how they made sense of their difficulties in a moment characterised by urgency and vulnerability.

For three mothers, entry into PIFC followed prior engagement with generic PIP within the broader PPIMHS when their infants were very small. Their accounts of PIFC were therefore shaped by earlier therapeutic experiences that appeared continuous with, rather than separate from, this later intervention.

Early feeding-related crisis and urgency

Across accounts, referral to PIFC was precipitated by experiences of acute crisis, most often centred on feeding and difficulties with weaning (with its inherent developmental movement toward separation). These were described as urgent, desperate and emotionally charged situations in which time felt scarce and solutions elusive.

Lia, Priya and Marcia explicitly identified their infants' refusal to feed or wean as the primary presenting concern at PIFC entry.

Priya stated that:

"*He had a feeding problem, he was not eating anything" (P2, 7)*

"The main issue was the feeding" (P2, 9)

"He was a risk" (P2, 83).

Lia described PIFC as having:

"[L]anded at the right time as Ibi was doing the whole… I'm now just going to shove it in and gag… I was at my wit's end, because I'm like, not only trying to get her to eat, she's trying to choke us out… she rejected any kind of solids, she was in love with her bottle suddenly at six months, that's all she wanted" (P3, 10)

"[A]s soon as I would come around the side of her chair, she threw things, or she'd shut her mouth. She wouldn't want to touch anything when I was near, so it was a very tricky one… we didn't know what to do" (P3, 12).

"We were struggling… found ourselves in that really strange place" (P3, 10)

Feeding here had become a site of rupture and escalating distress, accompanied by a loss of maternal confidence and direction.

Marcia similarly described stalled progress and mounting anxiety:

“He would not feed, he would only want milk, his weaning was really delayed” (P4, 2)

“*We were giving time to establish feeding, but it wasn't going anywhere. Musa was just not having any solids at all” (P4, 4)*

“Weaning was not happening; therefore, my child might be delayed developmentally, therefore might not grow the way he needs to, it will have all these negative repercussions “(P4, 48)

Fears about infant safety and health intensified this sense of crisis. Lia explained:

“My worry was whether Ibi would ever eat… it began as a real medical risk that shifted into fear. Once she gained weight the hospital wasn’t suddenly concerned but we still were” (P3, 30)

She described feeling trapped in repetition:

“We were like… is there any improvements we’re ever going to see? we were just going round in a circle, with all these pressures, worries, fears, but it’s never going anywhere because you are just repeating and going around and there’s baby trapped in the middle” (P3, 10)

In these accounts, feeding refusal became equated with developmental derailment and potential long-term harm.

While feeding was often the explicit presenting problem (symptom), it also operated as a proxy for broader relational and regulatory concerns (symbol).

Sana differentiated feeding from what she experienced as the core difficulty:

“*Feeding was part of the issue, he was very fussy with everything” (P1, 110)*

“He was not eating… but there was a lot of the other stuff” (P1, 118)

“Feeding was not the main thing; it was not aimed at the feeding clinic in particular” (P1, 32)

For her, feeding provided the concrete entry point into PIFC, through which wider emotional distress and relational vulnerability entered clinical attention.

Sana also described a broader collapse of confidence and agency in early motherhood:

“I felt so helpless” (P1, 124)

“Like why this all is happening to me” (P1, 68)

Her fears extended into catastrophic anticipations:

“It felt like Abdul was broken forever, he’s never gonna be able to thrive, he’s never going to settle at school, I will probably have to home school him” (P1, 200)

Priya described feeding difficulties alongside communication delay and separation anxiety:

“He was also not speaking” (P2, 9)

“It was very hard with him, he was only with me, was not sitting separate from me” (P2, 21)

Sana also described social withdrawal and separation difficulty:

“He was scared of everyone, he was not out, he wasn’t doing anything” (P1, 120)

“*I could not send him to nursery, he was very scared of the separation” (P1, 196)*

Across accounts, feeding and weaning unfolded within climates of fear and uncertainty rather than mutual regulation and pleasure. It became saturated with anxiety, standing for broader concerns about safety, development, relational rupture, and irreversible harm, intensifying the need for external containment and support.

Early trauma and medicalisation shaping the present

Mothers described arriving at PIP and later PIFC following early experiences of trauma and medical intervention that shaped both maternal and infant wellbeing and their relationship, which was closely linked to feeding and developmental concerns.

Marcia described Musa's arrival as already marked by vulnerability and loss:

"Musa was premature, four weeks early, I had some problems in the pregnancy, it was a very stressful time, because I'd lost a baby before I had him, so Musa was super precious… the pregnancy had been very difficult, I'd been in and out of hospital, it was a very traumatic delivery. I had complications with caesarean and ended up in high dependency unit… everything was very traumatic" (P4, 2)

Feeding was medically complex from the outset:

"*Feeding was hard to establish" (P4, 2)*

"[H]e was poor when he started feeding, struggled initially to breastfeed… he was hypoglycaemic, struggled to get his latch onto the breast, we had to do lots of manoeuvres in hospital, including attaching a little tube to the nipple" (P4, 20)

Lia similarly described the shock and sustained pressure following the discovery of congenital anomalies:

"We found out we were having a baby with defects… massive shock, lots of tests" (P3, 2)

“There was massive separation at the start... you don’t sleep, you don’t know what going on… so there’s massive emotional impact and trauma” (P3, 23)

She described entering a state of chronic survival:

“*We entered this pattern of growing this baby, kind of keep this baby alive” (P3, 8)*

“We were told … if she doesn’t have the nose, they’ll go in the stomach, the pressure is on, right?” (P3, 10)

Early bodily closeness was therefore mediated by medical procedure and survival, overshadowing ordinary relational beginnings where feeding could be based on mutual regulation:

“Ibi was tube fed for a long time… when it came to weaning, she didn’t take it well at all” (P3, 4)

“*I went from breastfeeding to holding a tube within weeks, it felt alien and disconnecting with no time to process it” (P3, 8)*

Sana described trauma emerging from domestic violence:

“After he was born, I went through domestic violence… Abdul was only three months old when I left his dad… because of the trauma, I became very unwell – physically and emotionally… had suicidal thoughts, they sent me to MAU” (P1, 34-6)

Relational rupture was intensified by enforced separations through contact arrangements:

“*At the contact centre they literally snatched him from me and gave him to his dad… he cried the whole hour and vomited after every contact. They wouldn’t give him back to me” (P1, 156)*

She perceived a profound impact on her infant:

“He ended up with this big trauma – he is scared of everyone, doesn’t go out, cries in his sleep, he’s terrified, he went through a sort of depression” (P1, 120)

“*He was mentally very disturbed and traumatised – had PTSD or whatever he had” (P1, 136)*

In this context, feeding difficulties were embedded within broader experiences of fear and instability.

Priya likewise described persistent medical vulnerability:

“They said my placenta is not working, he needs emergency c-section… since then I was very scared, he was one month in special care… always in hospital, in and out, he would vomit too much, he was very small and premature” (P2, 65)

“*When he was 9 months old, he had hernia operation… chest infections” (P2, 69*)

She recalled ongoing physical fragility:

“It was hard, he cried a lot, had a breathing problem, reflux, vomiting, it was difficult to manage that” (P2, 23)

For Marcia, medical vulnerability intersected with contextual pressures and separation at weaning:

“*The six-month weaning time coincided with starting nursery and me going back to work… that’s when the struggles began. He started getting sick, had upper respiratory tract infection, wouldn’t feed, only want milk” (P4, 2)*

“There was a lot going on… I hadn’t wanted to go back to work so quickly, it was taking me away from my baby and those cuddling… I was the breadwinner… my husband had immigration problems” (P4, 44)

Disruption of maternal role, emotional regulation, and felt connection with the infant

Alongside feeding crisis and trauma, mothers described a profound disruption in their sense of themselves as mothers and in their felt connection with their infant. Experiences of anxiety, low mood, and emotional dysregulation were central to the parent-infant relationship and were particularly evident in what led Sana, Lia and Marcia to PIP prior to PIFC, when their infants were still very young.

Lia described how early motherhood was fundamentally altered by medical stress:

“Motherhood wasn’t new… but it was a different ball game ‘cause we had the added medical pressure of Ibi’s health… we came into this already quite in a different playing field, with a different set of stresses” (P3, 6)

Motherhood was experienced not as a gradual settling into relationship, but as entry into a high-alert, survival state.

For Sana, disruption was located explicitly in depression and impaired bonding:

“*I was going through depression, it was really hard to bond with my son” (P1, 40)*

She described the absence of an expected maternal instinct:

“That natural thing you are supported to feel… oh my god, that’s my child, I need to protect him, I want to play with him, that nurturing nature was not there… there was a brick wall between me and him” (P1, 44-6)

This was experienced as both sadness and a rupture in maternal identity, articulated through a painful split between practical care and emotional presence:

“I was doing all what he needed - food, clothing… but there wasn’t any emotional attachment” (P1, 42)

Distress was experienced somatically as well:

“I was very stressed, physically and emotionally, I developed physical symptoms… weakness in my leg” (P1, 36)

Marcia similarly described perinatal anxiety and emotional instability:

“I had a lot of leftover guilt and emotional dysregulation… anxiety on the pregnancy… I think it was much more anxiety than depression” (P4, 2)

Internal dysregulation formed the emotional backdrop against which early parent-infant relationships developed, potentially undermining mothers’ confidence in their capacity to offer security, containment, and connection to their infants.

For Lia, the disruption took the form of perceived loss of maternal instinct:

“*We started a reconnection at about 6 months of feeding… we’d lost time. There was panic, fear, guilt. It was roller coaster… I lost months of instinct with my baby, I lost my intuition and Ibi was clearly trying to find some kind of connection with me through feeding” (P3, 10)*

These reflections convey grief and longing alongside an awareness of missed early relational experiences that felt difficult to repair.

Maternal identities were further destabilised by external pressures and internalised ideals.

Sana described being consumed by court processes and violence:

"More focused on all that was going on with his dad, that I never had the feeling of being a mum" (P1, 54)

Social comparison intensified self-doubt:

"You know how you see on social media how you're supposed to feel… that natural thing – I wasn't that" (P1, 44)

Guilt and shame were pervasive:

"[A] lot of guilt I had… I was not able to be a happy mum" (P1, 68)

"I was a rubbish mum, I felt so guilty. I am not able to do things that all these people are doing" (P1, 72)

B. Mothers' experience of change in their infants

This theme captures how mothers experienced, recognised, and emotionally responded to change in their infants over the course of PIFC. Infants' presence within sessions appeared central, as mothers could directly observe shifts in feeding, regulation and engagement.

From distress to relief – noticing that something is improving

Mothers described an initial sense of relief as feeding became less distressing, signalling that something was starting to change. Feeding, previously saturated with anxiety and struggle, became less fraught. Improvements in feeding were frequently experienced as signs of progress and achievement, carrying a strong positive emotional impact.

For Priya, change was experienced in concrete terms:

“It is good, I have seen lots of changes in my son, because of this help he started eating” (P2, 3)

“[H]e started eating cookies and rice, sausages, that was a bit relief” (P2, 46)

Her emotional response was immediate and closely tied to observable progress:

“I am very happy, I achieved quite a lot” (P2, 59)

“When he started eating, I was happy” (P2, 33)

For Priya, who had not previously engaged in PIP, feeding functioned initially as a clear behavioural marker of improvement. Change was visible, measurable, and directly reassuring.

In contrast, other mothers described change more as a reduction in overall tension and in relational or affective terms. Lia reflected:

“*It is calmer, she certainly does less of everything” (P3, 34)*

Relief here was linked not simply to feeding, but to diminished distress and struggle. She noted:

“We’ve got to the point where she is eating, she is safe, stable, taking calories, she’s doing well” (P3, 16)

Feeding was experienced as embedded within a broader sense of safety and stability rather than an isolated outcome.

Marcia similarly described gradual progress:

“He did start taking solids” (P4, 40)

“[T]he feeding team introduced more of a variety of food” (P4, 36)

“*Musa got to bringing in tiny bits of actual food and eating” (P4, 10)*

These accounts convey feeding as slowly becoming possible rather than forced, movement emerging where there had previously been stasis.

Sana did not emphasise change in feeding in the same way. Given that feeding was not her primary concern, this divergence highlights variability in how change was located and prioritised across mothers. For her, change was more visible in relational and emotional domains. This absence may also reflect the focus of the interview rather than the absence of change itself.

Across these accounts, relief appeared to precede reflective understanding. Mothers often described emotional reassurance before they could articulate what had changed or why or what weaning/feeding now meant for them.

Experiencing the infant as more regulated, communicative, and safe in relationships

Beyond feeding, mothers described changes in how they experienced their infants emotionally and socially. Infants were perceived as calmer, more communicative, more socially confident, and increasingly able to tolerate separation. These changes were deeply reassuring and reshaped mothers’ sense of their child’s developmental trajectory.

For Sana, change was experienced as transformative. Prior to PIFC:

“My son would not go to anyone, he was scared of everyone, of being left alone. I remember the first session he would not come through the door, he was really scared to make contact, that something will happen, he will be left alone” (P1, 168)

She attributed subsequent change to the therapeutic relationship:

"*She [PIFC] helped him build up his confidence, the person I brought in and the person that left was completely changed" (P1, 168)*

"[H]e became more confident, slowly, slowly… from that scared traumatised boy, he got the experience of being confident" (P1, 196)

"[N]ow he is completely fine" (P1, 198)

Changes in emotional regulation and communication were closely intertwined. Sana described how initial withdrawal gave way to aggression, and then to verbal expression:

"[L]ater he was not expressing himself, he was not talking, and then he was aggressive, hitting… his needs changed, he was not scared but was aggressive, and we started working on finding a way to express… he found the words… it really helped him to settle down" (P1, 196)

She observed steady progression:

"*Each week he was progressing, better at communicating" (P1, 202)*

Relational safety extended beyond the therapy room. Nursery attendance became possible:

"He started nursery, because of all the work we had been doing that year, it really helped him. She [PIFC] would try to speak to nursery, she was very helpful with the outside world as well, not just the sessions, 'cause they don't really take the word from you, they think you are a protective parent. She spoke to them, and they took her seriously… so helpful honestly" (P1, 196)

This external validation and triangulation supported not only the child's adjustment but also Sana's sense that her son could now be understood and held within relationships beyond the dyad.

Sana also expressed experiences of change in attachment:

"It mainly changed my son… me too… he built such a strong relationship and bond with her [PIFC], like mummy I miss her… the last session I remember walking down this corridor and him telling me mummy I love her, and this was a boy that could not form any bonds or relationships" (P1, 196)

For Priya, changes were similarly evident, though described more behaviourally:

"*When he started it was really hard with him, he wasn't like he is doing now, playful" (P2, 19)*

Over time, she noted increased independence, framed as durable and developmentally forward-moving:

"Now he is separate, that has not gone back" (P2, 31)

"[H]e is going to nursery, socializes and mixes up with other children" (P2, 32)

Communication improved:

"*He developed his confidence, he was not talking to anybody, now he would try to ask and answer questions" (P2, 99)*

"[W]hen I take him to the nursery his behaviour is ok, he is proud of that" (P2, 95)

Lia described transformation in vivid contrast to earlier fragility:

"[S]he's happy full stop… Ibi just turned into this really robust, bubbly, happy glorious toddler who charges around… she's climbing, she's jumping, she is daredevil, she is full of life… you would never know looking at her of her journey… she is not a child that has shrunk with that, she's big as in personality, as in energy…. if her entire experience had just been crazy, hypervigilance and stress… people ignoring her needs and what she was asking, I wonder whether she'd be that big now, or whether she'd be a bit smaller… more introverted" (P3, 34)

Here, change was understood not only as improvement, but as protection against longer-term relational vulnerability.

Across accounts, infants were increasingly experienced as emotionally safer – able to engage, communicate, separate, and participate in relationships with greater confidence. However, not all mothers described changes in emotional regulation or relational capacity. Marcia did not explicitly describe changes in these areas, indicating variation in how change was located and articulated across participants.

C. Mothers' experience of change in themselves

This theme captures how mothers experienced changes in themselves across emotional, reflective, representational and relational domains. For Sana, Marcia and Lia, these developments appeared cumulative, unfolding across earlier PIP engagement and subsequent PIFC work. While changes in infants were experienced as meaningful, mothers most frequently located transformation within themselves – in their growing capacity to regulate emotion, make sense of their own and their infants' experiences, trust their instincts, and reposition themselves in relation to both their infants and professionals.

These accounts suggest that increasing reflective capacity—the ability to think about internal emotional states—supported shifts at a representational level, reshaping how mothers experienced themselves, their infant, and the relationship. Rather than operating as discrete processes, the subthemes appeared closely interconnected. Developments in emotional regulation and reflective understanding seemed to create conditions in which representational change could emerge, which was subsequently associated with later experienced changes in the parent-infant relationship.

In this sense, boundaries between themes were necessarily porous. The analytic distinction between subthemes reflects interpretative organisation rather than separate experiential stages, as mothers' accounts suggested an unfolding process in which changes within the self gradually reorganised relational experiences. The subsequent GET concerning changes in the relationship can therefore be understood as emerging from, rather than independent of, these earlier internal and representational changes.

Priya's account engaged less strongly with several of these subthemes, which may reflect her position at earlier stage of therapeutic change at the point the intervention ended. Beyond emerging confidence and initial perspective shifts, her narrative suggested processes that were beginning rather than consolidated, alongside a continued need for therapeutic scaffolding. This may indicate that further therapeutic work may have supported the development of additional changes observed in other participants, and that she may have been approaching readiness for referral to ongoing PIP intervention.

Feeling more contained and supported

A central change involved becoming less overwhelmed. Mothers described reductions in fear, guilt, and "all-or-nothing" pressure, alongside greater calm and tolerance.

These changes were closely linked to feeling held within a steady and containing therapeutic relationship.

Sana reflected:

“I was not so scared, I was not as uncertain with everything, I did not feel like it was all or nothing” (P1, 200)

“His mother was not so anxious anymore, ‘cause she had learnt” (P1, 202)

She described change in how she could respond under stress:

“[B]efore I used to think… any small thing, I will be so angry and helpless. He screamed… I could not manage, they helped me to be this calm” (P1, 228)

This change was attributed to PIP and PIFC therapists’ capacity to think alongside her rather than react:

“She [PIP] being calm, picking on things and thinking there with me… with Mary [PIFC] not overacting, allowing space, wanting to understand” (P1, 204)

Containment was experienced relationally. Through the therapist’s emotional availability, steadiness, persistence, and repeated follow-ups, projections were received and transformed. Sana emphasised:

“*[S]he [PIFC] was keeping on top of everything, following me up… making sure I was attending” (P1, 184)*

“[S]he had a good understanding of the things that I have been through... of what I needed” (P1, 186)

Feeling understood and held in mind seemed crucial:

"*[I]t is very easy for me to hide away, not having to face any reality, if I was late or I did not come to an appointment she was always checking up on me like she minded" (P1, 150)*

For Sana, this containment began in PIP. She described how overwhelming experience transformed into manageable and less self-blaming:

"[H]elping to break things down… and like sort of understanding what I am going through, it is not my fault" (P1, 68)

"I would bring a mountain with me of this is shit, this is happening to me, I am drowning, and she [PIP] was really calm… she would have one word, and this would bring manageable chunks for me" (P1, 96)

PIP was also described as protection during acute vulnerability:

"I used to get those suicidal thoughts… but then I would speak to her [PIP], she would help me to think through these things… things would seem a lot easier, and these thoughts would kind of go down until they would build up over the week… so she kind of help me to settle down and live" (P1, 106)

"I was not cured but it helped, I was better" (P1, 214)

"She [PIP] helped me with my trauma and my bonding with my son" (P1, 136)

Change was therefore experienced as partial but life-sustaining.

Reduction of guilt accompanied this emotional regulation. Sana noted:

"[T]he guilt was a bit aspect" (P1, 76)

"I realised that I was trying my best and I was not the worst mum on the planet" (P1, 92)

For Lia, containment meant having space for her own emotional reality. She reflected:

“[T]his year has been truly horrible. It got to the point where I will talk about the baby, all the stress… and then I mentioned other things… she [PIFC] was like... tell me more about that... that was nice” (P3, 32)

“*I found those conversations very useful because for me it not only reminds to stop and breath and take a stock and respect the trauma my family has gone through… it’s always a reminder to me to go oh wow, ok, take a moment for ourselves” (P3, 48)*

Therapy provided recognition of trauma, validation and containment, enabling mothers to pause and reflect on experiences that had previously felt overwhelming or unthinkable. Lia described finding space to articulate intense and previously unspoken feelings connected to early separation and loss:

“[I]t just gave me the space to be like that was awful… I hate my husband because he got to be with my baby at birth and I didn’t… he couldn’t be with me when I needed him… it got me to say all those things about the initial stuff, about my experience as well as my many concerns around Ibi” (P3, 2)

“*I had space to work through some of that in those sessions” (P3, 16)*

She contextualised this within systemic gaps in postnatal care:

“*There is no aftercare. Your physical care is good, but there’s nothing that supports… nothing in there was for me… it was all baby” (P3, 22)*

Against this backdrop, protected therapeutic time was essential:

“[T]o have that one hour a week where I would just be like… this is killing me... I feel like I’m failing. I hate my life right now... having that space to just say what’s happening for me” (P3, 22)

Lia also described how the therapist actively redirected attention towards her own experience supporting emotional awareness:

“[I]t was always like, well how’s the week? Tough week? Why? And me… well it’s not baby, it’s my other children... tell me that… ‘cause the I’m here for Ibi, overrode everything else” (P3, 38)

She particularly valued the integration of emotional space and practical guidance within the PIP/PIFC intervention, describing how this balance enabled both immediate coping and deeper reflection:

“I’ve always found the balance of the space to talk, the actual doing the Tea tasks… having the directive questions or doing the feeding clinic, role play stuff… but also the very practical suggestions… the whole package was incredibly useful” (P3, 44)

“[T]here is that balance between this is an emotional thing but, in the meantime, we practically have to get through it” (P3, 44)

For Lia, the cumulative nature of therapeutic work was explicit; change was not attributable to a single intervention but to layered relational experiences.

Containment also altered how uncertainty was held:

“[C]oming to terms with that unknown again… this is just the next step of the unknown” (P3, 30)

“*[W]orking on this acceptance, trust and just kind of going with the flow” (P3, 30)*

Marcia similarly described sessions as psychologically restorative:

"*[M]y time, my space… I was going with my baby, but it was about me… I had to go through a lot of my own mental health issues, it was hard" (P4, 56)*

Sessions were also described as movement toward self-compassion:

"I can see more the positives… I can more understand that I don't have to feel guilty all the time about everything" (P4, 30)

This fostered greater internal sensitivity*:*

"[I]t made me more sensitive to my own feelings and more able to prioritize my own mental health" (P4, 52)

Across accounts, emotional containment reduced emotional dysregulation, softened guilt and self-criticism, and expanded tolerance for uncertainty. Containment appeared cumulative and enacted through continuity, steadiness, and therapists' emotional presence and availability. It did not eliminate difficulty, but it rendered experience more thinkable and survivable.

Restoring Confidence and Maternal Instinct

Several mothers described a restoration of maternal confidence and responsiveness toward their infant, which appeared closely linked to emerging changes in the parent-infant relationship. Mothers described becoming better able to read their child's cues, tolerate distress without panic, and trust that the infant could be understood rather than managed through fear or control.

For Sana, this change was substantial and explicitly empowering:

"*[I]n my encouragement and capabilities… I gained a lot of confidence, greatly, that is not an impossible task raising my son" (P1, 200)*

Confidence developed through observing and internalising the PIFC therapist's stance:

"*I saw progress in him and some of the things I picked up from her [PIFC] in terms of how she dealt with him... it poured confidence in me" (P1, 200)*

This changed how she conceptualised her child:

"[I]t gave me this certainty that my son isn't broken forever despite what he experienced" (P1, 200)

It also strengthened her maternal identity:

"Sessions helped me in my role as a mother" (P1, 226)

"I needed somebody, they [PIP/PIFC] both empowered me, they built me back up again" (P1, 206)

For Sana, restored confidence seemed inseparable from a reorganisation of meaning and representation; the child was understood to have changed from "damaged" to "developing", and the mother from "helpless" to "capable".

Priya described a similar process, though framed in more concrete terms. Early fear dominated her experience:

"[B]efore I was scared, since he was born" (P2, 65)

Within sessions, the therapist's calm modelling, which may also reflect Priya's experience of being emotionally contained within the therapy, functioned as scaffolding:

“[I]n one session he was crying too much... she said it is ok, just relax” (P2, 85)

Trust in professional guidance was central*:*

“I trusted her, I followed her, and it worked” (P2, 89)

“[S]he gave me some confidence... that was the main thing” (P2, 78-9)

She linked improvement directly to therapist observation:

“[F]ew things she [PIFC] saw in him, what I had to do... that is why he improved” (P2, 61)

Crucially, guidance around pausing reduced reactive escalation:

“[H]e used to cry a lot… she said let him have a few minutes, he will calm down… then after two minutes he was relaxed” (P2, 35)

Through repeated experiences of the infant settling without urgent intervention, Priya’s fear gradually gave way to trust, both in her child’s capacity to regulate and in her own ability to wait.

What began as external guidance became internalised. This shift extended to help-seeking:

“[B]efore I used to stay at home, now I am more confident to ask for support and help” (P2,103)

For Lia, the restoration of maternal instinct was described as reclaiming something that had been “shut off” by prolonged medicalisation and fear. During pregnancy and early infancy, medical authority had overridden her internal knowing. She emphasised the important of having that instinct legitimised:

“[H]aving that space [PIP] to talk about the doctors are saying this, but my instinct says my baby’s not happy and have somebody hear that” (P3, 22)

“[S]he [PIP] absolutely listened…was so welcoming, that space gave me the ability to reconnect to my own maternal instinct, which had been shut off… the clinical side of medicine takes over, and the emotional side just goes into shutdown... it tapped back into my instinct” (P3, 22)

Therapeutic enquiry and validation repositioned the infant as a subject:

“*[H]aving someone… well tell me more about your instinct, what is she telling you? What are you seeing in her? As if Ibi was a person and not just a baby with a heart problem... it helped” (P3, 22)*

“*[T]hese conversations with somebody that looks at your tiny baby like they’ve got their own feelings and thoughts” (P3, 16)*

“[H]aving somebody constantly remind me that my baby’s not just a body going through a physical thing helped me connect back to my instinct” (P3, 26)

Maternal instinct was therefore restored not only as a feeling of confidence, but as a relational stance from which the infant was seen as emotionally intentional and communicative rather than defined by medical vulnerability.

While Marcia did not explicitly frame her experience in terms of maternal confidence, this process appeared implicitly present within her narrative. Her descriptions suggested gradual shifts toward greater ease and responsiveness with her infant, indicating an emerging sense of maternal competence that was enacted rather than directly named.

Shifts in perspective and maternal authority

A further dimension of change involved mothers reinterpreting their experiences and repositioning themselves as thinking, deciding parents. Change was not primarily about acquiring techniques, but about strengthening agency and parental authority within complex emotional, relational, and institutional contexts, alongside enhanced reflective capacity – the ability to think and feel while holding both their own and their infant's subjectivity in mind.

For Sana, this change was explicit. Through prior PIP, she reframed herself not only as a survivor of domestic violence but as someone with agency:

"*[S]he changed that for me, yes, I was the victim of DV but I had power, I had control more than I knew it" (P1, 84)*

"I realised I had more authority than I thought I did, I was not a child anymore" (P1, 92)

This repositioning marked a movement from helplessness to parental authority, recovering her sense of herself as a thinking adult capable of protecting her son from her own projections.

For Sana and Marcia, perspective shifts were also rooted in linking present difficulties to earlier life experiences. Sana recognised longstanding patterns of unconscious thought and behaviour:

"[C]omparing his to my childhood that was not that great either… I was always protecting my siblings from my parents" (P1, 76)

"[T]hat came up, my own experience of my parents, and their conflict between them" (P1, 78).

Sana also saw how this repeated in adulthood:

"*[T]hat was one of the things she [PIP] helped to kind of get through, that is separate… when it came to my son, I felt when all these things were happening around me with my ex-partner and stuff, I still went into that subconsciously… I was trying to fight against the parents, the adult or authority figures" (P1, 84)*

She described a striking representational shift:

"[O]ne of the biggest things was that I was seeing my son as my sibling rather than my son... weird" (P1, 78)

This recognition increased capacity to differentiate between past and present, child and adult, preventing generational confusion:

"*I am not completely organised, but I am able to not let his past trauma be present... have gained a lot from the therapy" (P1, 228)*

Marcia also linked her distress to early family dynamics, breaking idealisation into a more integrated state of mind where emotional pain is recognised:

"I really struggled with my first child… part of it is related to my own relationship with my mum, who I kind of placed on a pedestal of perfection, *when I fell short of that… that exacerbated how I felt emotionally and it didn't help because my mum would say sometimes things that were making things a lot worse for me" (P4, 20)*

Marcia also recognised the enduring impact of childhood abuse:

"*I had a history of abuse as a child… the effects that had on my mental health which I hadn't really appreciated, it was hard to work through… and how it still does have its own repercussion, because it doesn't ever leave you" (P4, 76*)

Marcia's insight emerged through therapeutic reflection:

“I became more aware of it all only because it was pointed out to me... I don’t think I would have necessarily realized it myself” (P4, 50)

“*The reflective sessions were very important, I needed that space and time, I wouldn’t have found it for myself (P4, 56)*

This awareness changed her maternal positioning:

“[B]efore it was always about the care of Musa… I need to be amazing for him, but sessions enabled me to be more able to say no, you need to look after you, without it you can’t look after him (P4, 52)

Guilt and perfectionistic expectations were increasingly reflected upon and transformed rather than eradicated. Marcia described becoming more aware of how self-criticism and religiously inflected guilt shaped her emotional experience and her relationship with her son:

“*I hadn’t appreciated how much influence it was having on my relationship with my son, or just generally, how I was feeling… the sort of guilt side was mixed in with religion as well” (P4, 24)*

Feelings of inadequacy were pervasive, expressed through a sense of needing constantly to apologise:

“[A]lways feeling like you have to say sorry or be sorry… you’re not a good enough mother… I apologized to my son, like I’m sorry mummy does not manage to get you to eat” (P4, 28)

Over time, this rigid ideal softened as she began to recognise: “*there is no perfection” (P4, 26),* mourning the loss of an imagined ideal of motherhood*:*

“I was sad about not being able to wean my son, because I just wanted everything to be perfect” (P4, 28)

This example highlights the overlap between this subtheme and the preceding theme of increased containment. For Marcia, change involved both reduced anxiety and greater understanding, suggesting that emotional distress was not eliminated but transformed through awareness of unconscious emotional dynamics. As she reflected, *“change was mainly in my understanding and my level of anxiety”* (P4, 48), illustrating the interconnected development of emotional regulation and perspective change.

Notably, the need for help itself initially evoked shame: *“I felt I was a bit of a failure… the fact that I needed the sessions made me feel a bit like you should be able to feed your child… shouldn’t need to have help to do that”* (P4, 20).

Lia described perspective change as “zooming out” to see the wider picture:

“[PIFC] helped to see this is actually what the entire pictures looks like right now, having that accepted and something that could be spoken about in that space was very useful… sometimes things can live in silo… without ever zooming out and looking at how everything is interconnected” (P3, 32)

She valued being able to articulate the impact on the whole family:

“[T]here were those moments where the invitation was there to not just make it about Ibi or myself… because ultimately there’s an entire family…. how everything is interconnected, the impact on everyone… the whole picture when it finally comes together felt really good, like you’re doing all the caretaking for everyone but who looks after you? that kind of allowance was really beneficial for me” (P3, 32)

"*[E]verything impacted on my family in a way that I wouldn't have had a clue… I genuinely believe the landscape of my family would be different today if it weren't for having that support… it'd be different for worse. I'd never felt lost in that two years of support… I would not have been able to go on this journey and still hold down a job and everything else, ask of my husband what I needed, to be the mum that Ibi needs" (P3, 34)*

Validation and insight supported differentiation between genuine concern and hypervigilance:

"*[H]aving that ability to literally show someone [PIFC videos] what is happening inside your house is so useful… is this me? Is this my hypervigilance right now?... was really useful to separate out… hang on, is that just me panicking about something? because I'm now obviously aware that over the duration for the two years I was on edge" (P3, 46)*

"[H]ave another set of eyes on this… cause after a while you're like … there clearly this thing going on but because I'm so involved, the primary carer, I don't know how to get out" (P3, 30)

This strengthened agency extended into decisive action within medical hierarchies. Lia described the pivotal moment of removing her daughter's feeding tube:

"*[T]o talk about the doctors are saying this, but my instinct says my baby's not happy and have somebody hear that… suddenly I was… what have I been doing, Ibi's telling us she doesn't want it" (P3, 22)*

"*[H]aving her there to be like, yes, she's telling you something… I just felt really sure of myself, it gave me that strength to say that's not right. I don't know if I would have*

felt that empowered to do that up against all these clinical gods… they're not the ones with her afterwards. It galvanized me to be able to say to the doctors this is what we are doing, this is why, this has just not come out of thin air, I've got this other support and I pulled the tubes" (P3, 26)

"*I've got to be the best I can be… I lean into it" (P3, 18)*

Authority here was enacted under uncertainty. She acknowledged ongoing vulnerability:

"*[W]e are still no closer… we still have the next journey and the next journey, but it is how we approach that journey" (P3, 30)*

Confidence was therefore less about eliminating uncertainty and more about tolerating it.

Her reconnection with maternal instinct and increasing parental authority was accompanied by a reduction in hypervigilance:

"[T]he easing off on the fear, not gripped by the holding patterns, the hypervigilance, that's all mine, not baby's" (P3, 16)

This recognition appeared linked to earlier changes in emotional regulation and a growing sense of internal containment.

Early in the work, Priya described relying on the therapist's direction to support her son's growing independence:

"[S]he [PIFC] told me to just leave him alone a bit so that he is able to engage" (P2, 21)

"[S]he [PIFC] advised that I take him to groups, that nursery is better" (P2, 31)

“[S]he told me this will allow him to become independent and then you can drop him to nursery” (P2, 85)

“[S]he told me it will be hard for you, but you have to do it” (P2, 39)

Over time, these external suggestions and guidance appeared to become internalised, informing her own understanding and decision-making. She reflected:

“I have seen myself I should keep him away from me” (P2, 39)

“I realised nursery is the best place” (P2, 57)

“[N]ow I take him walking” (P2, 79)

This shift was accompanied by a broader change in perspective, as she described learning through the sessions:

“I learnt quite a lot in the sessions… language, personality wise” (P2, 101)

This was accompanied by increased awareness of her own responses*:*

“I realised even if he is not asking, I am still giving” (P2, 41)

These accounts suggest a movement from reliance on professional authority toward the gradual development of her own parental authority, enabling decision-making aligned with her child’s developmental needs.

Emerging confidence appeared linked to growing reflective awareness of her emotional state and its impact on her child. As Priya noted:

“[S]he said when you are scared, if you are relaxed… he will feel comfortable as well” (P2, 71)

Through this process, Priya appeared better able to regulate her fear, tolerate separation, and position herself as a thinking, deciding parent, rather than responding primarily from anxiety. Although these shifts had relational implications, they are presented here as changes within Priya's developing parental perspective, which appeared to precede later relational reorganisation.

As mothers described becoming more emotionally regulated and reflective, changes were increasingly experienced not only within themselves but within the relational space between mother and infant. The following theme therefore explores how these internal changes were experienced as changes in the relationship itself.

D. Change in the mother-infant relationship

Building on the internal and representational shifts described in the previous theme, mothers began to experience changes in the quality of interaction and emotional connection with their infants.

This theme captures how relational change was experienced through shifts in interaction, emotional tone and responsiveness. Mothers rarely spoke about "the relationship" in conceptual terms. Instead, change was conveyed experientially through pauses, responding differently, allowing separation, and noticing emerging moments of connection and enjoyment. These developments appeared closely linked to mothers' internal changes described in theme C.

Compared with earlier themes, relational change was less explicitly articulated. However, accounts suggested that as mothers became less anxious and more emotionally regulated and contained, interaction increasingly allowed for curiosity, affective attunement and emotional availability. The relative indirectness of these

descriptions may reflect both the subtle, embodied nature of relational change and the methodological reliance on maternal narrative, rather than dyadic observation.

Moving from reactivity to greater curiosity

This subtheme captures a shift in relational stance moving from reactive, anxiety-driven, or punitive responses toward curiosity about infants' internal worlds. Curiosity gradually replaced alarm; understanding replaced immediate correction.

Several mothers described how observing the therapist's stance supported this transition. Sana contrasted the therapist's reflective and observant approach with her own habitual directive one, creating space for thinking within interaction:

"He would be playing and she [PIFC] would be observing… she never kind of went oh no, no, no, this is what you have to do… she kind of analysed his behaviour and asked me for my input. She put limits, she was very understanding… like that clock right there he got really obsessed with. I was like no, no, no, don't do it, and she was like it's fine… she would give him the clock to look at. She picked up the receiver and kind of let him lead… he did not feel he is wrong" (P1, 168)

What struck Sana was the therapist's pause, becoming less punitive:

"From her [PIFC] what really stayed… for the rest of my life… the initial reaction to anger, he needs to be stopped, that was not there. No matter what, she would always wait one second… the way she would interpret his behaviour… that curiosity really stuck, let him explore and be his own individual and follow his steps rather than dictating. Initially he was very scared, and she let him have his time… there was not pushing, having that patience and curiosity… for other parents that might come out naturally but for me it wasn't" (P1, 188-190)

The “second” before intervening became symbolically important as a space in which thinking replaced reactivity.

Curiosity also reframed behaviour as communication. Sana described how this changed her interpretation:

“He was throwing some blocks, and she would say really nicely, oh, so you are showing this is how you are feeling… normally I would be like he is throwing stuff, so he is misbehaving, naughty… but she used to be curious… it is not that he is misbehaving” (P1, 173)

This shift supported a new perception of the infant, as a separate individual with intentions and emotional states:

“It led to understanding him as an individual being with his needs, his views and wants” (P1, 182)

“I became more confident in understanding his behaviour” (P1, 202)

Relational change here involved recognising the infant as intentional and communicative, rather than oppositional.

Lia became more reflective, developing curiosity about inward processes. She described “unpicking” the relational dynamic:

“*We did a lot of unpicking… because there’s a dynamic between Ibi and me that can only get better if I also acknowledged that the situation led to a really high level of hypervigilance in me… then I’m pushing that stress… it’s just oozing back out of me, back onto my child… and I had space to work through some of that, think about the impact on Ibi” (P3, 16)*

Lia also described becoming less reactive within family dynamics:

"*[S]o unpicking that and learning to just not respond or react… and let my husband take charge … be more relaxed" (P3, 30)*

She recognised how her emotional state and vigilance entered the relational field, becoming aware that the responsibility for the interaction did not reside solely within the infant. As she reflected:

"*[A]s ibi's interacting more and I'm worrying less about her, my brain starts picking up on, okay, so she [PIFC] is asking all these questions, oh, she's actually asking about me [laughter]. I had this kind of light bulb moment… of course, it's not a one-part journey" (P3, 32)*

This moment of recognition marked a shift from locating difficulty entirely within the infant toward understanding the relationship as co-constructed, shaped by both her infant's experience and her own emotional responses. Her growing capacity to reflect on her own contribution to the relational dynamic enabled greater flexibility and responsiveness within interaction. These relational changes were closely interconnected with earlier changes described in GET C, particularly the development of reflective capacity and maternal authority, suggesting that changes in how she understood herself as a mother were inseparable from changes in how she experienced and engaged in the relationship with her infant.

Marcia described becoming aware of her infant's sensitivity to her emotional state:

"She [PIFC] would notice things like, if I was sad or crying, baby would crawl up to me and try and cuddle me… I hadn't appreciated that he was noticing that, and he would

try to provide some comfort to me… so it would be the therapist saying it, I hadn't realized that" (P4, 50)

"PIFC sessions were good, first of all looking at the bond between me and Musa, whether he was picking up on any of that transferred anxiety… it was felt that the bond was really positive… but when I get tearful about other things, then he would stop whatever he was doing… playing… and sort of stare at me… he was very much aware of when I was unhappy" (P4, 10)

Marcia repeatedly described becoming more aware of how her own emotional wellbeing affected her infant:

"It enabled me to have more of an idea of how my own emotional mental health, well-being, would impact Musa and it was good because it made me more like what's the best way? (P4, 52)

Marcia also recognised how earlier anxiety and guilt shaped interaction:

"*I became aware that I was very anxious with him, because of the pregnancy had been so difficult, I had a sort of guilt that he wasn't breastfeeding" (P4, 6)*

"I was hyper, wanting to establish the bond, because I wasn't able to carry him as much as I wanted to (P4, 50)

Across accounts, relational change seemed both subtle and cumulative. As mothers became more regulated internally, they opened a space in which the infant increasingly appeared as a subject with feelings and intentions, rather than as a problem to be managed.

Experiencing greater emotional closeness while allowing separation and autonomy

Mothers described entering new relational phases characterised by playfulness, mutual enjoyment, and connection beyond caregiving demands.

Lia described a marked transformation in the emotional quality of her relationship with Ibi:

"*Ibi and I have entered this new really sweet phase. I've always been the not fun one, doing the medical appointment, the nappies… but we've entered this really nice little place where she wants me randomly, not just for things… she will come and just ask for a cuddle, putting her head on my shoulder and turning my face to her, and just smiling at me. There's just more playfulness, connection that isn't just solely reliant on certain things, and when it is connected to the food now it's calmer… there's less need for her to get my attention through dropping food and pretend gagging" (P3, 34)*

Her account conveys a relational reorganisation. Connection became less instrumental and more spontaneous, supporting both emotional closeness and reduced feeding-related distress.

Marcia described something slightly different; not so much a newly formed bond, but a recognition of a bond that had been obscured by fear and guilt:

"The bond was already very close, but I think I hadn't realized that I had managed to do that" (P4, 50)

As anxiety reduced, affection became more visible:

"[W]ith Musa, it's now a much more affectionate kind of relationship… he doesn't think I'm going to tell him off, he will tell me things" (P4, 60)

She also valued the protected therapeutic space:

"*I longed for that space and time when it would be just us, that was our time, nothing really to fear with that space" (P4, 58)*

For Marcia, relational change involved the easing of self-criticism and fear, allowing warmth already present to be experienced consciously.

Importantly, mothers also described a growing capacity to tolerate separation and to support their infants' autonomy without experiencing this as relational loss. Sana described how separation was approached developmentally rather than through pressure:

"[S]he would say we are going towards you leaving out the room and him staying with me… to help him overcome the trauma that he thinks I am not going to come back… but that did not happen, and she did not push for it" (P1, 190)

This absence of coercion appeared central; separation became something scaffolded rather than imposed, allowing autonomy to emerge within relational safety.

Similarly, as illustrated in earlier subthemes, Priya increasingly recognised and supported her child's need to separate and engage with the social world beyond the family home.

E. New understanding of feeding and weaning in light of change

By the time mothers spoke about feeding differently, significant emotional and relational shifts had occurred. In general, mothers had become less overwhelmed, more reflective, and more able to experience their infants as communicative and emotionally accessible. Feeding did not change in isolation; rather, it was reorganised

within the context of broader relational transformations. It also became less about achieving intake and more about sustaining connection.

The analytic significance of this theme therefore lies not in further internal maternal or relational change—addressed in Themes C and D—but in how feeding itself came to be understood, experienced, and enacted differently. Feeding emerged as a site where prior emotional and relational shifts became concretely expressed.

Feeding as a source of confusion and disruption

Prior to therapeutic change, feeding and weaning were experienced as confusing, distressing, and disorganising. Feeding was shaped by competing medical and developmental expectations that often felt disconnected from infants' cues. As responsiveness and relational meaning diminished, feeding became dominated by schedules, targets, and external demands, emerging as a source of pressure, uncertainty and relational strain. These experiences were articulated most explicitly and reflectively by Lia and Marcia.

For Lia, feeding had become profoundly detached from her infant's bodily experience:

"I described it to PIP therapist as we're making foie grass; we're just pouring milk into her. She has no say over a schedule. When we took the tube out, she didn't even know what hunger was… everything was the physical, feed, feed, feed… in the end Ibi was like, get off and for a little while I didn't listen to that. We got really messed up in our head from the months of disconnection… and suddenly I was oh god, what have I been doing, she's telling us she does want the tube" (P3, 26)

Here, feeding was experienced as something done to her infant rather than with her.

Marcia described similar confusion, particularly in the context of her infant's illness, nursery care, and conflicting expectations:

"He was kind of caught in the middle in terms of how he should be feeding" (P4, 2)

"[T]here was a disparity between how I was trying to wean and how nursery was trying to… it was getting confusing" (P4, 4)

She also described holding contradictory understandings of feeding, comfort, and development:

"I understood that actually milk is the main source of nutrition for a child under the age of one, he was not feeling well to eat, he needed the comfort" (P4, 48)

Earlier feeding practices were shaped by developmental expectations rather than infant readiness:

"It went into how I was trying to feed him… I would sort of just stop kind of force feeding… but then when he didn't want to feed, I was still trying to feed him, because I thought ok, he needs to eat, he's eight months, milk is not enough… that kind of approach was not helpful" (P4, 10)

Reframing feeding difficulties as meaningful

Feeding difficulties were also increasingly understood as meaningful forms of communication rather than signs of failure, opposition, or deficit.

For Lia, this reframing involved recognising feeding behaviours as relationally shaped:

"*She's gone from tube to bottles and then being put in a chair so she was like don't want that… she learnt very quickly that if she took a little while… at first gagging, because of the tube and choking, but then because of the reaction she got from me…*

she entered a mummy can look after me this way… if I gag and choke and drop things in my mouth or if I don't eat… she was trying to choke us out" (P3, 10)

Feeding refusal was no longer understood as random or oppositional, but as embedded within relational interaction and emotional meaning.

Marcia described reframing feeding in light of her infant's vulnerability:

"*He didn't feel well, he did not want to start sitting there trying to eat food, he just needed the comfort of milk" (P4, 48)*

This change involved relinquishing rigid developmental expectations and understanding feeding as relational and experiential rather than outcome driven:

"I realised that actually weaning is about experience for the child, it's about a fun kind of sensory tactile experience … it's not just about getting calories into the baby… so yeah that was really important" (P4, 56)

This reflected a movement away from performance-based feeding expectations toward recognising feeding as responsive to the infant's emotional and developmental needs. As feeding was re-understood as experiential and relational, maternal practices changed accordingly:

"[W]e took a more relaxed approach, just sort of taking cues from Musa, as to what he wanted in terms of feeding… we did some sessions on play feeding… pretending to eat then bringing tiny bits of actual food and eating together" (P4, 10)

"Musa responded positively, like he enjoyed it" (P4, 12)

"*[T]he sessions helped because at home we made eating into more play, fun kind of activity… more exploring of the food… so we did a lot of sessions with that and then slowly he started swallowing some of the food and that went fairly well" (P4, 42)*

Play became a bridge between emotional safety and feeding engagement.

Priya described similar changes in how feeding was emotionally framed:

"She [PIFC] said let him sit with you… say oh the food is very nice, and he became more interested" (P2, 37)

"Don't say in front of him that he does not eat, say that he eats everything… talk like that" (P2, 95)

Feeding was reshaped through language, affect, and shared attention rather than pressure.

For Lia, feeding was also re-located within broader family life:

"Feeding and food is family… it's a fundamental part of family life… So, when you're doing a feeding clinic, I think at some point there should be that opportunity of let's look at the wider dynamic, because at the end of the day, me and Ibi can do whatever we want, we're still at the table with four other people… involving people on that journey I think is useful" (P3, 42)

Feeding thus became no longer located solely within the mother-infant dyad but embedded within shared family practices and relational systems.

While Sana did not share feeding change in the same way, her account linked feeding difficulties to trauma and overwhelm, suggesting that feeding functioned less as a

primary site for change and more as one element within broader relational and emotional recovery.

F. Engagement with PIFC: expectations, facilitators, and barriers

This theme captures the relational and systemic conditions that shaped how mothers entered, engaged with, and remained in PIFC. Engagement was experienced as contingent on trust, continuity, personal capacity, and systemic responsiveness. These conditions could either support engagement or undermine it at points of acute vulnerability.

Expectations of rapid repair versus hopes for understanding

Mothers entered PIFC in contexts of crisis, often hoping that the intervention would resolve feeding difficulties, trauma, or developmental concerns. Feeding difficulties represented fears of irreversible harm, intensifying the expectation that intervention might restore safety and normality.

Lia described reaching out at a point of emotional overwhelm and uncertainty:

"[I] really struggled and needed emotional support… and trying to get my head around what this meant I reached out" (P3, 2)

For Sana, expectations were closely linked to repair and recovery from trauma:

"*[T]o get back to normal… all these horrible stories he's gone through – it's going to fix it" (P1, 144)*

"[I]t was a lot for my son, he was really traumatised… the thing I wanted to work with was… to help him get rid of this trauma" (P1, 118)

“[T]he feeding, and the big trauma that he ended up with – I needed somebody to help sort that out for me so he can start going into nursery” (P1, 120)

She distinguished between PIP and PIFC:

“[W]ith Michelle [PIP therapist], she was helping with my own trauma… my bonding with my son (P1, 136)

“[W]ith Mary [PIFC therapist], sessions were mainly focused on my son” (P1, 166)

“[T]o help him understand his trauma, making him confident, in playing with other people, come out of the house” (P1, 180)

Engagement was initially framed through hopes for resolution:

“*[I]t’s helping me somehow cause we are going to come out with a solution or we are going to come up with something” (P1, 156)*

“I wanted to be a happy mum” (P1, 70)

Over time, however, some mothers described a change from expectations of rapid repair toward a focus on understanding and tolerating uncertainty.

Lia articulated this movement away from cure toward meaning:

“*[I]t’s about at least if you can make sense of something, you can approach something in a different way… and leaning into the free fall… accepting that sometimes I don’t have the answer and I can’t fix everything” (P3, 28)*

“I don’t think I went with any expectations… I guess, a little hope we’ll get some insight into why Ibi’s trying to drop food, because then if you can gain some insight, you know what you’re working with” (P3, 30)

She explicitly rejected expectations of immediate resolution:

"*I'd never go in like oh this is going to fix anything… there's no magic pill to fix anyone…. if you can make sense of something you can approach something in a different way" (P3, 30)*

Sana similarly recalibrated her expectations retrospectively:

"I expected an intensive intervention… it will be quick, to help him forget everything… it did not happen, but it was not a bad thing… even though it was once a week, it turned out to be for good… his needs changed because I was seeing her" (P1, 198)

In contrast, Marcia entered PIFC without a clearly formed expectation due to emotional overwhelm:

"I think I was very open… I didn't have any expectations as such… there was too much emotionally going on for me… I was really not in a good place emotionally, *wasn't able to think ok this is what this is going to do" (P4, 54)*

Across accounts, engagement evolved from hopes for repair toward a capacity to use therapy as a space for understanding, reflecting a shift from seeking solutions to developing understanding.

Personal and systemic barriers to engagement

Engagement was shaped by systemic factors including accessibility, continuity, communication and service visibility. Moments of transitions—assessment, waiting periods, and endings—were experienced as particularly vulnerable points.

For Sana, the PIFC assessment process itself was experienced as distancing and impersonal, undermining engagement:

"*[I]t was not helpful. I had to tell her everything… and then [sigh] we were waiting for somebody else… it's like going to the doctor… telling what your problem is and then ok I know what your problem is go home" (P1, 160)*

"*[I]t felt harder to open up… like I was telling any random person on the street my problems" (P1, 162)*

"*[T]here was no communication, no follow up, nothing, it was like going from being very supported to this dead silence and no support [baby cries]"* (P1, 128)

These disruptions occurred within the context of depression, which reduced her capacity to initiate contact:

"[M]y mental health was not in the best state to contact the service" (P1, 130)

"[I]f you feel depressed you would not reach out. I finished a year and a half treatment, but I still needed the reassurance of we are here… to have trust that help is coming… if I'm depressed, I'm never gonna call, I don't give a shit about this crisis number… you need to feel a connection with somebody" (P1, 208)

Once treatment began, relational continuity repaired this rupture:

"*[T]hings kind of got better in terms of communication… consistency, every week… she [PIFC] was checking up with me" (P1, 150)*

Cultural context also shaped engagement, introducing an additional burden of explanation:

"[C]ultural difference was present though not openly discussed… I will have to explain" (P1, 218)

“[I]t would be helpful to be a little curious about why rather than that is not right… especially in my culture, women do not talk” (P1, 222)

System-level barriers were also evident in the visibility of the service. Marcia noted limited awareness even among healthcare professionals:

“[W]e, as in the doctors, don’t know that these services exist… we don’t know how to get people into these services… I was very fortunate that I got into that service through the perinatal team” (P4, 80)

Lia similarly highlighted inequality of access:

“I feel a bit sad that this potentially isn’t open to everyone” (P3, 34)

Endings were also experienced as shaped by service structure rather than clinical readiness. Priya described leaving PIFC when the therapist went on extended leave while still struggling. Sana reported continuing to need support for herself. Marcia described her son as still “picky”, despite improvement. These accounts suggest that therapeutic endings did not necessarily coincide with a sense of resolution, notwithstanding partial yet meaningful internal and relational transformations.

Trust, continuity, and relationship as facilitators of engagement

Trust, continuity, and the therapeutic relationship itself were central facilitators of engagement, often experienced as more influential than the technical elements of the intervention. Where PIFC followed earlier PIP work, this continuity provided a relational foundation that supported openness and depth.

Lia described how prior therapeutic experience enabled her to engage more fully:

“I think being open means you’ve got more capacity to make the most of the opportunity, take it in, ask more questions, jump in, absorb more… being less resistant

or standoffish to what's being said… if you've got no experience of those conversations with somebody that looks at your tiny baby like they've got their own feelings and thoughts… some people might go into that being like what do you mean? They're just a baby… whereas having had that journey where I got to know Ibi… it made me more able to engage, led to probably having more in-depth conversations… than maybe the allocated sessions [PIFC] would have allowed… we might not have got there" (P3, 16)

Continuity also facilitated timely referral and anticipatory support:

"*[S]he [PIP therapist] got to know baby really well and said I will do a Feeding Clinic referral now, so that you're on the pathway… that was really important that we got the help that we needed… she had the foresight. I feel very lucky that it was that fluid and quick" (P3, 4)*

For Sana, PIFC built directly on relational foundations established in PIP:

"[A] lot of the other stuff had to be carried over from Michelle [PIP therapist] … by the time I met with Mary [PIFC therapist] the bonding had started to form with my son. So, things were not as bad … when I started seeing Mary [PIFC] it was all the other issues" (P1, 118)

Trust in therapy itself sustained engagement during difficult transitions:

"[T]he fire I had inside me that I wanted my son to get better… seeing him like that was horrible… Second part of it, having done the work with Michelle [PIP], I knew that once I get somewhere it is going to be good, help me… everything she's done to me I still held on… maybe if I hadn't had that experience I would be like this is a waste of time, pointless, I can't be helped" (P1, 208)

Feeling understood and not judged was particularly important:

“[Y]ou get judged a lot… I could say what I want without being judged, that meant a lot” (P1, 230)

For Priya, despite English not being her first language and interview being supported by an interpreter she stated that in her PIFC sessions: *“language was not a barrier” (P2, 101).*

Marcia located engagement partly in professional identity:

“*I’m a doctor anyway… I expect that of my patients… tell me their deepest, most sensitive bits of information… I didn’t find it difficult to do that with members of staff*” *(P4, 14)*

CHAPTER 4. DISCUSSION

This chapter integrates the findings of the present study with psychoanalytic, developmental, and Parent-Infant Psychotherapy (PIP) literature. Using Interpretative Phenomenological Analysis (IPA), the study foregrounded mothers lived experiences of change across emotional, relational, reflective, and representational domains during engagement in PIP within a specialist Parent-Infant Feeding Clinic (PIFC). In doing so, it extends existing literature by illuminating how change is experienced, rather than focusing solely on measurable outcomes.

Consistent with the limited qualitative exploration of mechanisms of change in PIP (Barlow et al., 2016; Fonagy et al., 2016), change emerged not as a linear symptom reduction but as a gradual relational process. It involved interconnected shifts in maternal containment, reflective capacity, and epistemic confidence, alongside infant regulation, relational safety, and the symbolic reorganisation of feeding. This aligns with multi-level models of therapeutic change in parent-infant psychotherapy (Jones, 2018), in which internal maternal change reorganises relational functioning and supports infant developmental progression.

These processes appeared to be mediated by continuity of care, prior therapeutic relationships, and systemic conditions, reflecting infant mental health literature that emphasises the interplay between intrapsychic and organisational containment (Fonagy & Allison, 2014; Menzies Lyth, 1960). Notably, explicit descriptions of “relational change” were often indirect. This may reflect the ways in which mothers conceptualise change (often in terms of personal shifts), the feeding-focused framing of PIFC, or the limitations inherent in how relational change is operationalised and measured in both qualitative and quantitative research.

The discussion is structured around eight domains that relate to the original aims of the study while also considering the wider implications of the findings. *Containment, mentalization, and the restoration of psychic safety* and *Reclaiming maternal authority and epistemic trust* explore how mothers perceived, understood, and made sense of change within themselves, including shifts in their capacity to think about and respond to their infants. *Relational reorganisation and infant development* and *Feeding as symbolic and relational* address where change was located across the mother, infant, and parent–infant relationship, and how changes in feeding were understood within this relational context. *Engagement, continuity, and systemic containment* considers the internal, therapeutic, and external factors that facilitated or impeded change, including how expectations and engagement with PIP developed over time. The remaining domains—*Implications for clinical practice and service development*, *Methodological reflections*, and *Contribution to knowledge and future research*—extend these findings by considering their implications for the delivery and study of PIP. Together, the eight domains therefore provide a framework for addressing the study's central aim of understanding how parents experience and make sense of change in PIP within the context of infant feeding difficulties.

1. Containment, mentalization, and the restoration of psychic safety

Mothers described the early parent-infant relationship unfolding within contexts of trauma, medicalisation and uncertainty. Their experiences of overwhelm, anxiety and diminished confidence reflect psychoanalytic formulations of trauma states in which emotional excitation exceeds the ego's capacity for integration (Freud, 1926; Hopkins, 1986).

From Bion's (1962) formulation, this reflects failures of alpha function, in which raw and overwhelming emotional experience ("beta elements") cannot be metabolised by the mother and is instead evacuated through action. Feeding difficulties may therefore reflect disruptions in the maternal containment necessary for infants' emotional regulation, and infants' attempts to manage this disorganising situation.

Therapeutic containment emerged as central to change. Therapists' reliability, curiosity, and emotional availability provided a holding environment (Winnicott, 1960), in which mothers could begin to tolerate uncertainty, regulate their affect, and attend more sensitively to their infant. From a mentalization perspective, mothers moved from states dominated by hypervigilance and survival anxiety toward increased capacity to reflect on internal states, both their own and their infants' (Fonagy et al., 2002). This capacity developed through repeated experiences of being mentally held, consistent with Fonagy et al.'s (1994) account of reflective function as emerging through relational containment.

Continuity between generic PIP and specialist PIFC played a critical role. Although PIFC was theoretically positioned as an entry point to broader intervention on the parent-infant relationship, in practice if often functioned as a targeted continuation of prior PIP therapeutic work. Mothers referred following earlier PIP engagement demonstrated greater reflective depth, suggesting that containment and mentalization capacities develop cumulatively across therapeutic contexts, even when different clinicians are involved. In this sense, therapeutic processes scaffold one another and continuity enhances the consolidation of psychic integration. The referral pathway therefore may partially account for divergences observed across cases, particularly in the pace and visibility of reflective and relational change.

A key aspect of this integration involved increased capacity to tolerate guilt and shame. As persecutory anxiety softened, mothers became more able to tolerate ambivalence and imperfection without defensive retreat. This developmental movement reflects emergence from psychic retreat and consolidation of a more resilient maternal self, capable of reflective engagement in both their own and their infants' emotional experience.

2. Reclaiming maternal authority and epistemic trust

A central transformation involved mothers reclaiming confidence in their own perceptions, intuition, and decision-making. Early narratives frequently depicted maternal authority as undermined by trauma, medicalisation, and guilt. Maternal instinct was present but inaccessible, "shut off" by anxiety and self-doubt.

Therapeutic work supported restoration of epistemic trust (Fonagy & Allison, 2014) – the capacity to trust one's own interpretations while integrating external knowledge. Mothers did not simply follow advice; they internalised the therapist's reflective stance, enabling more flexible and confident responses to their infants.

This process aligns with Britton's (1998) concept of triangulation, in which mothers can hold and observe multiple perspectives without defensive collapse. Maternal authority emerged through relational validation and reflective dialogue. As mothers felt recognised and understood, the relationship with their infants became more guided by attuned understanding.

Change was facilitated not only through verbal insight but through lived relational experience. Observing the therapist's interactions with their infant enabled mothers to reinterpret infant behaviour and integrate new meanings in real time. Reflective

understanding and embodied relational experience operated together to support enduring change.

Parental change was predominantly described in individual maternal terms, despite partner involvement being available. This may reflect both the dyadic focus of intervention and broader caregiving norms. However, it highlights the importance of including fathers and partners in future research to better understand relational transformation at the family level.

3. Relational reorganisation and infant development

Mothers described their infants as becoming calmer, more communicative and emotionally engaged. These developmental shifts unfolded alongside maternal increases in containment and reflective capacity, suggesting interconnected transformation across intrapsychic and relational domains. This aligns with Jones' (2018) model of levels of change in parent-infant psychotherapy, as well as attachment and developmental systems perspectives that conceptualise infant regulation as co-constructed within relational interaction (Bowlby, 1988; Tronick, 2007).

Infants' movement from distress and hyperarousal toward exploration and engagement mirrors Winnicott's (1965) description of developmental progression from survival to play, where play signifies psychic safety and symbolic capacity. Feeding interactions gradually became sites of shared experience and mutual responsiveness, reflecting broader reorganisation of the parent-infant relationship.

These findings highlight the interaction between relational and constitutional influences on development. While classical psychoanalytic theory emphasised innate predispositions toward anxiety and aggression (Freud, 1926), contemporary

psychoanalytic (i.e. object relations) approaches and developmental research highlights how trauma and stress disrupt regulatory systems (Schore, 2001; van der Kolk, 2005). Individual differences in resilience further mediate developmental trajectories (Masten, 2001; Rutter, 2012). Therapeutic containment appeared to support restoration of regulatory capacity by re-establishing relational safety, suggesting that constitutional vulnerabilities are not removed but modulated within a containing relational environment.

Consistent with trauma-informed developmental theory, parental reflective function operates as a key protective mechanism supporting emotional regulation and resilience (Fonagy et al., 1994; Hopkins, 1986; Pynoos, 1992). As maternal mentalizing capacity increased within a containing relationship, infants demonstrated improved regulation, separation tolerance, and exploratory behaviour, suggesting consolidation of secure-base functioning (Bowlby, 1988).

Notably, relational change was often implicit rather than explicitly articulated, echoing findings that improvements in parental or infant functioning may exceed detectable changes in relational indices (Barlow et al., 2016; Fonagy et al., 2016). Change appeared enacted through interaction rather than verbally foregrounded, suggesting that mothers may experience transformation primarily as internal shifts that nonetheless reorganise the relational field.

Variation across cases reflected developmental timing, maternal mental health, prior therapeutic experience, duration and intensity of therapy, clinician seniority (trainee versus consultant) and systemic context, underscoring the idiographic nature of therapeutic change. For younger infants, change was primarily described in regulatory terms, whereas for older toddlers it became more visible through play, autonomy, and

separation. Cultural and socioeconomic positioning may also have shaped engagement with services and experiences of professional authority, factors increasingly recognised as influencing outcomes in infant mental health contexts (Barlow et al., 2016).

4. Feeding as symbolic and relational

Initially, feeding was experienced as pressured, medicalised and emotionally fraught, undermining maternal competence and relational safety. Feeding interactions became confusing and anxiety-laden, making it difficult for mothers to integrate infant cues, professional advice, expectations and their own embodied understanding.

These findings support relational models that conceptualise feeding as embedded within affective and symbolic processes (Klein, 1952; Winnicott, 1988), extending empirical research linking parental anxiety to intrusive feeding practices (Stein et al., 2001, 2001b; Birch & Davison, 2001). Within this framework, feeding difficulties may be understood as expressions of unprocessed emotional experience under conditions of insufficient containment (Bion, 1962). This aligns with psychoanalytic understandings of feeding as a primary site of early object relations, where bodily experience, dependency, aggression, and love are symbolically negotiated within the developing parent-infant relationship (Klein, 1952).

Over time, feeding was re-symbolised as communicative rather than oppositional. The movement from procedural or forceful feeding toward responsive, play-based interaction reflects a developmental shift toward depressive-position integration, in which ambivalence and limitation become tolerable (Klein, 1952). Consistent with Jones' (2018) notion of symbolic change, this transformation was facilitated by the

infant's presence in sessions, allowing relational dynamics to be observed and understood in real time (Salomonsson, 2017). As Fonagy et al. (2002, 2016) note, reflective change is most effective when grounded in live interaction, where regulation is co-constructed in the immediacy of the therapeutic encounter.

Feeding thus shifted from symptom to relational process, reflecting broader reorganisation of meaning and regulation.

The Triadic Emotional Approach (TEA) may have been particularly significant in facilitating this shift in the meaning and experience of feeding. As a distinctive component of the PIFC intervention, TEA brought together a practical, play-based engagement with feeding and an underlying psychoanalytic understanding of the emotional and relational meanings associated with taking in, refusing, giving, and receiving food. Through the use of symbolic play within the therapeutic encounter, feeding could be explored outside the pressured context of mealtimes, creating opportunities for mothers and infants to experience greater curiosity, pleasure, and reciprocity. From this perspective, TEA may have provided a bridge between psychoanalytic understanding and observable relational experience: rather than relying solely on verbal interpretation, emotional meanings could be enacted, observed, and gradually transformed within the triadic therapeutic space. The findings therefore suggest that TEA may offer a valuable model for future specialist feeding interventions, particularly where feeding difficulties are intertwined with parental anxiety, trauma, difficulties in containment, and disruptions in the parent–infant relationship.

5. Engagement, continuity, and systemic containment

Engagement with PIFC was profoundly shaped by continuity, accessibility, and systemic responsiveness. Where services were experienced as coherent and connected, they functioned as institutional holding environments (Menzies Lyth, 1960), supporting containment and sustaining therapeutic progress. Conversely, fragmentation, delays or disruptive transitions intensified vulnerability and undermined trust, particularly for mothers already experiencing depression or trauma. These findings highlight the importance of integrated care pathways in maintaining engagement and supporting therapeutic change within vulnerable parent-infant dyads.

Endings did not always coincide with resolution, reflecting the non-linear nature of relational development and reinforcing concerns regarding short-term outcome evaluation in PIP research (Barlow et al., 2016). Rather than representing cure or definitive resolution, change was more often experienced as a gradual transformation. This resonates with Meltzer's distinction between cure and transformation, in which psychoanalytic work facilitates enduring shifts in emotional meaning and relational capacity rather than symptom elimination (Meltzer, 1975). What appeared to remain internalised was not technique, but the relational experience of being held emotionally, being recognised, and being thought about within the therapeutic relationship, further demonstrating containment as a central mechanism of change.

6. Implications for clinical practice and service development

The findings reinforce that effective parent-infant psychotherapy is fundamentally relational. Therapeutic change emerged through containment, restoration of maternal reflective capacity, and symbolic reorganisation rather than through technique delivery

alone (Bion, 1962; Fonagy et al., 2002). They also highlight the cumulative nature of therapeutic trajectories, whereby earlier interventions scaffold subsequent engagement and deepen change.

Clinically, interventions should prioritise containment, support the restoration of epistemic trust, and conceptualise feeding difficulties within relational and symbolic frameworks. Working with the infant present appears particularly important in facilitating embodied and interactional change. Video-based interventions may offer an additional means of supporting this process by enabling parents and therapists to observe moment-to-moment interactions and attend more closely to infant cues, parental responses, and emerging patterns of reciprocity. Used sensitively within a containing therapeutic relationship, video may help make subtle relational changes more visible and available for reflection.

At a service level, continuity, integration, and accessibility are essential. Services function as regulatory environments, and fragmentation or discontinuity risks replicating experiences of relational disruption (Menzies Lyth, 1960). These findings support the development and accessibility of specialist parent-infant psychotherapy interventions, including feeding clinics, alongside greater inclusion of fathers and couple dynamics to promote wider relational reorganisation.

Such developments could be situated within the *Start for Life* and Family Hubs framework, which provides an important opportunity to strengthen specialist support for parent–infant relationships during the first 1,001 days. Specialist parent–infant psychotherapeutic interventions based within, or closely linked to, Family Hubs could enable closer collaboration with health visitors, midwives, perinatal mental health services, and early years professionals, while providing families with more accessible

routes into relationally focused support. Within this model, specialist approaches such as the Triadic Emotional Approach (TEA) could provide a targeted intervention for families experiencing feeding difficulties, integrating practical, play-based work with psychoanalytic attention to the emotional and relational meanings of feeding. Parent–infant psychotherapists could also contribute through consultation, supervision, and training for these professionals, supporting earlier recognition of relational difficulties and strengthening the capacity of universal and early years services to think about infant emotional development alongside parental mental health and presenting concerns such as feeding difficulties. This model could facilitate earlier intervention while providing clearer pathways into specialist treatment when more intensive psychotherapeutic work is required.

7. Methodological reflections

IPA enabled detailed exploration of subjective experiences of change; however, findings reflect maternal accounts rather than direct observation of dyadic interaction, limiting triangulation. While the small sample constrains transferability, it strengthens ideographic depth and theoretical resonance.

The transition from Personal Experiential Themes (PETs) to Group Experiential Themes (GETs) required balancing abstraction with fidelity to lived experience (Smith et al., 2009). Although this process facilitated identification of shared patterns, it also raised the possibility that developmentally and phenomenologically singular aspects of experience might be diluted through generalisation. Many excerpts resonated across multiple domains, reflecting the inherently intertwined nature of emotional, relational and behavioural processes and challenging discrete thematic boundaries.

Experiences of change were non-linear and overlapping, often unfolding simultaneously rather than sequentially, requiring analytic flexibility to preserve experiential complexity. Maintaining proximity to the text—including allowing excerpts to inform more than one domain—was therefore a deliberate methodological decision aimed at preserving nuance and preventing interpretative coherence from eclipsing participants' meaning-making.

The interviews did not explicitly operationalise "change" beyond open exploration, and alternative prompts may have elicited different constructions. How parents themselves conceptualise change—whether as symptom relief, emotional regulation, relational shift, or identity transformation—warrants further investigation, particularly given the difficulty of articulating change shortly after intervention.

8. **Contribution to knowledge and future research**

This study contributes to Parent-Infant Psychotherapy (PIP), infant mental health and feeding research by providing qualitative exploration of mechanisms of change where feeding difficulties were central. The findings illuminate relational and regulatory processes often insufficiently captured in outcome-focused research (Barlow et al., 2016; Fonagy et al., 2016), supporting a developmental model in which maternal containment and reflective functioning reorganise dyadic regulation and enable infant developmental progression (Bion, 1962; Fonagy et al., 2002; Bowlby, 1988; Tronick, 2007; Jones, 2005, 2010).

The study advances a relational reconceptualisation of feeding as communicative and regulatory rather than purely behavioural, while offering empirical support for continuity-of-care models by demonstrating how therapeutic containment may

accumulate across services. Methodologically, the findings contribute to ongoing debates regarding the measurement of relational change, suggesting that transformation may be enacted and embodied rather than explicitly articulated within standardised outcome frameworks.

Future research would benefit from the inclusion of fathers and partners; the integration of qualitative and observational approaches (e.g., video-based work within PIFC) to examine micro-processes of relational change; the inclusion of measures such as parental embodied mentalising (Shai & Belsky, 2011); and longitudinal follow-up to explore the durability of therapeutic gains. Comparative work across service models and levels of continuity would further clarify organisational influences on outcome. Greater inclusion of culturally and linguistically diverse families is also needed, as variations in prior therapeutic experience and access to reflective language appear to shape engagement and meaning-making.

Overall, the findings provide empirical support for psychoanalytic and developmental trauma models, indicating that therapeutic containment may restore reflective function and support relational and developmental recovery following early disruption (Fonagy et al., 1994; Hopkins, 1986; Bion, 1962).

CONCLUSIONS

Overall, this study demonstrates that change in Parent-Infant Psychotherapy unfolds as a relational and developmental process, in which maternal containment, epistemic trust, and symbolic reorganisation reorganise the parent-infant relationship and support infant regulatory and developmental progression. By illuminating how feeding

difficulties function within relational systems, the findings extend existing PIP literature beyond symptom reduction to clarify mechanisms of change grounded in lived experience. Clinically, they underscore the centrality of containment, continuity, and the infant's presence in facilitating therapeutic transformation, while highlighting the importance of service structures as regulatory environments. Methodologically, the study contributes to ongoing debates regarding how relational change is conceptualised and measured, suggesting that its most meaningful expressions may be enacted rather than explicitly articulated. Future research integrating observational, longitudinal, and culturally inclusive approaches will be essential to deepen understanding of how therapeutic change unfolds across developmental and systemic contexts. Together, these contributions support a relational, developmentally informed model of intervention, reinforcing the unique role of Parent-Infant Psychotherapy in restoring developmental trajectories under conditions of early relational disruption.

Furthermore, since it is grounded in psychoanalytic theory, which emphasises the centrality of the dynamic unconscious (e.g., *Freud*; *Klein*; *Winnicott*), parent–infant psychotherapy requires clinicians to cultivate a particular kind of receptivity to unconscious communication. The material brought by parents and their infants is often conveyed through raw, unmentalised, and primitive states of mind that may be enacted rather than symbolised. In such contexts, the capacity for thinking can be compromised by the concreteness of experience, both in parents and in the intersubjective field. This places a specific demand on the therapist: to remain open to, and to be able to bear, intense affective states without resorting to defensive responses or premature interpretation. Developing this stance requires training, supervision and personal therapy that support the clinician's tolerance of uncertainty, affective intensity, and non-

verbal communication. In this sense, therapeutic availability is underpinned by a form of psychic resilience, enabling the therapist to stay engaged with the unconscious processes of the parent-infant dyad while maintaining a reflective position that can gradually facilitate insight.

REFERENCES

Ainsworth, M. D. S., Blehar, M. C., Waters, E., & Wall, S. (1978). *Patterns of attachment: A psychological study of the strange situation*. Erlbaum.

Archibald, M. M., Ambagtsheer, R. C., Casey, M. G., & Lawless, M. (2019). Using Zoom videoconferencing for qualitative data collection: Perceptions and experiences of researchers and participants. *International Journal of Qualitative Methods, 18*, 1–8.

https://doi.org/10.1177/1609406919874596

Aulagnier, P. (2001). *The violence of interpretation: From pictogram to statement*. Routledge.

Ban, L., Gibson, J. E., West, J., Fiaschi, L., Oates, M. R., & Tata, L. J. (2012). Impact of socioeconomic deprivation on maternal perinatal mental illness presenting to UK general practice. *British Journal of General Practice, 62*(603), 671–678.

Baradon, T., Biseo, M., Broughton, C., James, J., & Joyce, A. (2005). *The practice of psychoanalytic parent–infant psychotherapy: Claiming the baby*. Routledge.

Barlow, J. (2007). *Dispelling the ghosts in the nursery: Clients views about parent-infant psychotherapy*. Warwick Medical School: University of Warwick.

Barlow, J., Bennett, C., Midgley, N., Larkin, S. K., & Wei, Y. (2016). Parent-infant psychotherapy for improving parental and infant mental health. Cochrane Database of Systematic Reviews, 2016(1), CD010534.

https://doi.org/10.1002/14651858.CD010534.pub2

Barlow, J., Schrader-McMillan, A., Kirkpatrick, S., Ghate, D., Barnes, J., & Smith, M. (2014). *Health-led parenting interventions in pregnancy and the early years*. Department of Health.

Barrows, P. (1997). Parent-infant psychotherapy: A review article. *Journal of Child Psychotherapy*, *23*(1), 45–64.

Barrows, P. (2003). The therapist as a thinking object. *Journal of Child Psychotherapy, 29*(2), 201–218.

Beebe, B. (2000). Co-constructing mother–infant distress: The microcoordination of facial expression. *Infant Mental Health Journal*, *21*(1–2), 187–210.

Beebe, B., Lachmann, F. M., Markese, S., Buck, K. A., Chen, H., Cohen, P., Bahrick, L. E., Andrews, H., & Feldstein, S. (1997). Mother–infant interaction structures and presymbolic self and object representations. *Psychoanalytic Dialogues*, *7*(2), 133–182.

Beebe, B., & Steele, M. (2013). How does microanalysis of mother–infant communication inform maternal sensitivity and infant attachment? *Attachment & Human Development, 15*(5–6), 583–602. https://doi.org/10.1080/14616734.2013.841050

Berg, A. (2005). Cultural issues in parent–infant psychotherapy. In T. Baradon (Ed.), *The practice of psychoanalytic parent–infant psychotherapy: Claiming the baby* (pp. 174–190). Routledge.

Berlin, L. J., Zeanah, C. H., & Lieberman, A. F. (2008). Prevention and intervention programs for supporting early attachment security. In J. Cassidy & P. R. Shaver (Eds.), *Handbook of attachment: Theory, research, and clinical applications* (2nd ed., pp. 745–761). Guilford Press.

Birch, L. L., & Davison, K. K. (2001). Family environmental factors influencing the developing behavioural controls of food intake and childhood overweight. *Paediatric Clinics of North America, 48*(4), 893–907.

Bion, W. R. (1962). *Learning from experience*. Heinemann.

Bion, W. R. (1967). *Second thoughts*. Heinemann.

Bion, W. R. (1970). *Attention and interpretation*. Tavistock.

Bion, W. R. (1989). *Elements of psycho-analysis*. Karnac.

Bloomberg, L. D., & Volpe, M. (2023). *Completing your qualitative dissertation: A road map from beginning to end* (5th ed.). Sage.

Bowlby, J. (1969). *Attachment and loss: Vol. 1. Attachment*. Basic Books.

Bowlby, J. (1988). *A secure base: Parent–child attachment and healthy human development*. Basic Books.

Braun, V., Clarke, V., & Gray, D. (2017). *Collecting qualitative data: A practical guide to textual, media and virtual techniques*. Cambridge University Press.

Bretherton, I. (1992). The origins of attachment theory: John Bowlby and Mary Ainsworth. *Developmental Psychology*, *28*(5), 759–775.

Briggs-Gowan, M. J., Carter, A. S., Bosson-Heenan, J., Guyer, A. E., & Horwitz, S. M. (2006). Are infant–toddler social–emotional and behavioral problems transient? *Journal of the American Academy of Child & Adolescent Psychiatry, 45*(7), 849–858.

Britton, R. (1989). The missing link: Parental sexuality in the Oedipus complex. In R. Britton, M. Feldman, & E. O'Shaughnessy (Eds.), *The oedipus complex today* (pp. 83–101). Karnac.

Britton, R. (1998). *Belief and imagination: Explorations in psychoanalysis*. Routledge.

Brazelton, T. B., Koslowski, B., & Main, M. (1974). The origins of reciprocity: The early mother–infant interaction. In M. Lewis & L. A. Rosenblum (Eds.), *The effect of the infant on its caregiver* (pp. 49–76). Wiley.

Britton, R. (1989). The missing link: Parental sexuality in the Oedipus complex. In R. Britton, M. Feldman, & E. O'Shaughnessy (Eds.), *The Oedipus complex today* (pp. 83–101). Karnac.

Briggs-Gowan, M. J., Carter, A. S., Skuban, E., & Horwitz, S. M. (2006). Prevalence of social–emotional and behavioral problems in a community sample of 1- and 2-year-old children. *Journal of the American Academy of Child & Adolescent Psychiatry, 45*(7), 811–819.

Brown, G. W., & Harris, T. (1978). *Social origins of depression*. Tavistock.

Calvioni, G., & Galimberti, A. (2008). Parental feeding practices and children's eating behaviours: The role of control and responsiveness. *Infant Mental Health Journal, 29*(2), 1–15.

Chatoor, I., Ganiban, J., Colin, V., Plummer, N., & Harmon, R. J. (1998). Attachment and feeding problems: A reexamination of nonorganic failure to thrive and attachment insecurity. *Journal of the American Academy of Child & Adolescent Psychiatry, 37*(11), 1217–1224.

Chatoor, I., Hirsch, R., Ganiban, J., Persinger, M., & Hamburger, E. (1998b). Diagnosing infant feeding disorders: The infant feeding scale. *Journal of the American Academy of Child & Adolescent Psychiatry, 37*(8), 796–803.

Cohen, N. J., Muir, E., Lojkasek, M., Muir, R., Parker, C. J., Barwick, M., & Brown, M. (1999). Watch, wait, and wonder: Testing the effectiveness of a new approach to mother–infant psychotherapy. *Infant Mental Health Journal, 20*(4), 429–451. https://doi.org/10.1002/(SICI)1097-0355(199924)

Cudmore, L. (2007). Preventing emotional and behavioural disorders in children: The role of early parent–infant psychotherapy. *Child and Adolescent Mental Health, 12*(2), 89–94.

Department for Education, & Department of Health and Social Care. (2023). *Family Hubs and Start for Life programme*. UK Government publication.

Department of Health and Social Care. (2021). *The best start for life: A vision for the 1,001 critical days*. UK Government publication.

Diaz-Bonino, S., & Spencer, R. (2017). An evaluation of triadic relational development as a measure of infant receptivity to feeding and eating interactions: Development of the Infant Receptivity Scale. Poster presented at the International Attachment Conference, Paris.

Emanuel, L. (2011). Emotional experience and the parent–infant relationship: The thinking heart. *Journal of Child Psychotherapy, 37*(3), 659–675.

Fonagy, P. (1999). Psychoanalytic theory from the viewpoint of attachment theory and research. *Psychoanalytic Inquiry, 19*(5), 639–653. https://doi.org/10.1080/07351699909534278

Fonagy, P., & Allison, E. (2014). The role of mentalizing and epistemic trust in the therapeutic relationship. *Psychotherapy*, *51*(3), 372–380.

Fonagy, P., Steele, M., Steele, H., Moran, G. S., & Higgitt, A. C. (1991). The capacity for understanding mental states: The reflective self in parent and child and its significance for security of attachment. *Infant Mental Health Journal*, *12*(3), 201–218.

Fonagy, P., Steele, M., Steele, H., Moran, G., & Higgitt, A. (1994). The theory and practice of resilience. *Journal of Child Psychology and Psychiatry, 35*(2), 231–257.

Fonagy, P., & Target, M. (1997). Attachment and reflective function: Their role in self-organization. *Development and Psychopathology*, *9*(4), 679–700.

Fonagy, P., Gergely, G., Jurist, E. L., & Target, M. (2002). *Affect regulation, mentalization, and the development of the self*. Other Press.

Fonagy, P., & Allison, E. (2014). The role of mentalizing and epistemic trust in the therapeutic relationship. *Psychotherapy, 51*(3), 372–380.

Fonagy, P., Sleed, M., & Baradon, T. (2016). Randomized controlled trial of parent–infant psychotherapy. Journal of Child Psychology and Psychiatry, 57(6), 613–621. https://doi.org/10.1111/jcpp.12497

Fonagy, P., Allison, E., Campbell, C., & Bateman, A. W. (2019). Engagement and reflective functioning in parent–infant psychotherapy. *Attachment & Human Development*, *21*(4), 353–369.

Fraiberg, S., Adelson, E., & Shapiro, V. (1975). Ghosts in the nursery: A psychoanalytic approach to the problems of impaired infant–mother relationships. *Journal of the American Academy of Child Psychiatry, 14*(3), 387–421.

Freud, S. (1914). Remembering, repeating and working-through (Further recommendations on the technique of psycho-analysis II). In J. Strachey (Ed. & Trans.), *The Standard Edition of the Complete Psychological Works of Sigmund Freud* (Vol. 12, pp. 145–156). Hogarth Press.

Freud, S. (1926). *Inhibitions, symptoms and anxiety*. Hogarth Press.

Freud, S. (1940). Splitting of the ego in the process of defence. *International Journal of Psychoanalysis*, *22*, 65–70.

Georg, A. K., Kress, V., Fegert, J. M., & Schmid, M. (2021). Focused parent–infant psychotherapy for infants with emotional regulatory disorders: A randomized controlled trial. *Infant Mental Health Journal, 42*(6), 838–853.

Georg, A. K., Schmid, M., Fegert, J. M., & Kress, V. (2022). Mothers' experiences of focused parent–infant psychotherapy: A grounded theory study. *Infant Mental Health Journal, 43*(2), 265–279.

Glaser, D. (2000). Child abuse and neglect and the brain. *Journal of Child Psychology and Psychiatry, 41*(1), 97–116.

Hurry, A. (1998). *Psychoanalysis and developmental therapy*. Karnac.

Hopkins, J. (1986). The role of the psychotherapist in helping traumatized children. *Journal of Child Psychotherapy, 12*(1), 3–17.

Hopkins, J. (2018). *Infant–parent psychotherapy: Selma Fraiberg's contribution to understanding the past in the present*. In M. Rustin & J. Rustin (Eds.), *What can the matter be?* (pp. 87–102). Karnac.

Jones, A. (2005). Levels of change in parent–infant psychotherapy. In J. Baradon (Ed.), *The practice of psychoanalytic parent–infant psychotherapy: Claiming the baby* (pp. 106–121). Routledge.

Jones, A. (2010). Levels of change in parent–infant psychotherapy. In J. Baradon (Ed.), *Relational trauma in infancy: Psychoanalytic, attachment and neuropsychological contributions to parent–infant psychotherapy* (pp. 158–172). Routledge.

Jones, A. (2018). Levels of change in parent–infant psychotherapy. In A. Jones (Ed.), *Parent–infant psychotherapy: Psychoanalytic perspectives*. Routledge.

Khan, M. M. R. (1963). The concept of cumulative trauma. *Psychoanalytic Study of the Child, 18*, 286–306.

Keren, M. (2001). Regulatory disorders in infancy: Diagnostic and clinical issues. *Infant Mental Health Journal*, *22*(5), 586–594.

Klein, M. (1952). Some theoretical conclusions regarding the emotional life of the infant. In M. Klein, P. Heimann, S. Isaacs, & J. Riviere (Eds.), *Developments in psychoanalysis* (pp. 198–236). Hogarth Press.

Knoche, L. L., Sheridan, S. M., Edwards, C. P., & Osborn, A. Q. (2012). Implementation of a relationship-based school readiness intervention: A multidimensional approach to fidelity measurement for early childhood. *Early Childhood Research Quarterly*, *27*(2), 299–313.

Koulomzin, M., Beebe, B., Anderson, S., Jaffe, J., Feldstein, S., & Crown, C. L. (2002). Infant gaze, head, face and self-touch at 4 months differentiate secure vs. avoidant attachment at 1 year: A microanalytic approach. *Attachment & Human Development, 4*(1), 3–24.

https://doi.org/10.1080/14616730210123199

Larkin, M., & Thompson, A. R. (2011). Interpretative phenomenological analysis in mental health and psychotherapy research. In D. Harper & A. R. Thompson (Eds.), *Qualitative research methods in mental health and psychotherapy: A guide for students and practitioners* (pp. 101–116). Wiley-Blackwell.

Liotti, G. (2004). Trauma, dissociation, and disorganized attachment. *Psychoanalytic Inquiry, 24*(4), 472–499.

Lyons-Ruth, K. (2008). Contributions of the mother–infant relationship to dissociative and borderline symptoms. *Infant Mental Health Journal*, *29*(3), 203–218.

Lyons-Ruth, K. (1999). The two-person unconscious: Intersubjective dialogue, enactive relational representation, and the emergence of new forms of relational

organization. *Psychoanalytic Inquiry, 19*(5), 576–617. https://doi.org/10.1080/07351699909534270

Lyons-Ruth, K., & Spielman, E. (2004). Disorganized infant attachment strategies and helpless–fearful profiles of parenting: Integrating attachment research with clinical intervention. *Infant Mental Health Journal*, *25*(4), 318–335.

Masten, A. S. (2001). Ordinary magic: Resilience processes in development. *American Psychologist*, *56*(3), 227–238.

McDermott, B. M., Mamun, A. A., Najman, J. M., Williams, G. M., O'Callaghan, M. J., & Bor, W. (2010). Preschool children perceived by mothers as irregular eaters: Physical and psychosocial predictors from a birth cohort study. *Journal of Developmental & Behavioral Pediatrics, 31*(3), 197–205.

Mahler, M. S. (1967). On human symbiosis and the vicissitudes of individuation. *The Psychoanalytic Study of the Child*, *22*, 740–763.

Main, M., & Hesse, E. (1990). Parents' unresolved traumatic experiences are related to infant disorganized attachment status: Is frightened and/or frightening parental behavior the linking mechanism? In M. T. Greenberg, D. Cicchetti, & E. M. Cummings (Eds.), *Attachment in the preschool years: Theory, research, and intervention* (pp. 161–182). University of Chicago Press.

Masten, A. S. (2001). Ordinary magic: Resilience processes in development. *American Psychologist, 56*(3), 227–238.

McDermott, B. M., Mamun, A. A., Najman, J. M., Williams, G. M., O'Callaghan, M. J., & Bor, W. (2010). Longitudinal outcomes of feeding difficulties in early childhood. *Journal of Child Psychology and Psychiatry*, *51*(11), 1242–1249.

Meins, E. (1999). Sensitivity, security, and internal working models: Bridging the transmission gap. *Attachment & Human Development*, *1*(3), 325–342.

Meltzer, D. (1975). *Explorations in autism: A psychoanalytical study*. Clunie Press.

Menzies Lyth, I. (1960). Social systems as a defence against anxiety: An empirical study of the nursing service of a general hospital. *Human Relations*, *13*(2), 95–121.

Mersky, R. R. (2018). The challenges of being a mature doctoral student: The supportive role of vertical and lateral third spaces. In A. M. Cummins & N. Williams, (Eds.), *Further researching beneath the surface*, Vol. 2 (pp. 143–159). Routledge.

Miller, L. (2008). *The relation of infant observation to clinical practice in an under-fives counselling service*. In L. Emanuel & E. Bradley (Eds.), *What can the matter be?: Therapeutic interventions with parents, infants and young children* (pp. 38–53). Karnac.

Morrell-Scott, N. (2018). Using interpretative phenomenological analysis (IPA) to explore lived experience in nursing research. *Nurse Researcher*, *25*(5), 27–33.

Murray, L. (1997). The impact of postnatal depression on infant development. *Journal of Child Psychology and Psychiatry*, *38*(2), 99–101.

NHS England. (2017). *Implementing the five year forward view for mental health*. https://www.england.nhs.uk/publication/implementing-the-five-year-forward-view-for-mental-health/.

NHS England. (2019). *The NHS long term plan*. https://www.longtermplan.nhs.uk/.

Onions, C. (2009). Parent–infant psychotherapy. In M. Lanyado & A. Horne (Eds.), *The handbook of child and adolescent psychotherapy: Psychoanalytic approaches* (2nd ed., pp. 465–483). Routledge.

Pynoos, R. S. (1992). Traumatic stress and developmental psychopathology in children and adolescents. In D. Cicchetti & S. L. Toth (Eds.), *Rochester symposium on developmental psychopathology: Vol. 4. Developmental perspectives on trauma* (pp. 1–40). University of Rochester Press.

Raphael-Leff, J. (2008). *Parent–infant psychodynamics: Wild things, mirrors and ghosts*. Routledge.

Royal College of Psychiatrists. (2018). *Infant and early childhood mental health: The case for action*. Royal College of Psychiatrists.

Rustin, M. (2007). Psychoanalytic thinking, infant observation, and research. *Infant Observation, 10*(1), 1–15.

https://doi.org/10.1080/13698030601173775

Rustin, M. (2015). Research, psychoanalysis, and infant observation. *Infant Observation, 18*(1), 1–18.

https://doi.org/10.1080/13698036.2015.1013563

Rutter, M. (2012). Resilience as a dynamic concept. *Development and Psychopathology, 24*(2), 335–344.

Sadler, L. S., Slade, A., & Mayes, L. C. (2006). Minding the baby: Enhancing reflectiveness to improve early health and relationship outcomes in an interdisciplinary home-visiting program. *Infant Mental Health Journal*, *27*(6), 647–666.

Salomonsson, B. (2014). *Psychoanalytic therapy with infants and parents: Practice and theory*. Routledge.

Salomonsson, B. (2017). *The baby in the mirror: A child psychiatrist's reflections on parent–infant psychotherapy*. Routledge.

Salomonsson, B., & Barimani, M. (2017). Mothers' experiences of mother–infant psychoanalytic treatment: A qualitative study. *Infant Mental Health Journal, 38*(6), 757–769.

Salomonsson, B., & Sandell, R. (2011). A randomized controlled trial of mother–infant psychoanalytic treatment: I. Outcomes on self-report questionnaires. *Infant Mental Health Journal, 32*(2), 207–231.

Salomonsson, B., & Sandell, R. (2014). A randomized controlled trial of mother–infant psychoanalytic treatment: II. Predictors of treatment outcome. *Infant Mental Health Journal, 35*(3), 275–289.

Salomonsson, B., & Sandell, R. (2015). A randomized controlled trial of mother–infant psychoanalytic treatment: III. Infant outcomes. *Infant Mental Health Journal, 36*(6), 575–589.

Sameroff, A. J., & Fiese, B. H. (2000). Transactional regulation: The developmental ecology of early intervention. In J. P. Shonkoff & S. J. Meisels (Eds.), *Handbook of early childhood intervention* (2nd ed., pp. 135–159). Cambridge University Press.

Schore, A. N. (2001). Effects of early relational trauma on right brain development. *Infant Mental Health Journal, 22*(1–2), 201–269.

Schore, A. N., & Schore, J. R. (2008). Modern attachment theory: The central role of affect regulation in development and treatment. *Clinical Social Work Journal*, *36*(1), 9–20.

Shai, D., & Belsky, J. (2011). Parental embodied mentalizing. *Development and Psychopathology, 23*(3), 857–869.

Skovgaard, A. M., Houmann, T., Christiansen, E., Landorph, S., Jørgensen, T., Olsen, E. M., Heering, K., Kaas-Nielsen, S., Samberg, V., Lichtenberg, A., & Jørgensen, M. B. (2007). The prevalence of mental health problems in children 1½ years of age—The Copenhagen Child Cohort 2000. *Journal of Child Psychology and Psychiatry, 48*(1), 62–70.

Slade, A. (2005). Parental reflective functioning. *Attachment & Human Development, 7*(3), 269–281.

Sleed, M., Baradon, T., & Fonagy, P. (2013). New beginnings for mothers and babies in prison: A cluster randomized controlled trial. *Attachment & Human Development, 15*(4), 349–367.

https://doi.org/10.1080/14616734.2013.782651

Smith, J. A., Flowers, P., & Larkin, M. (2009). *Interpretative phenomenological analysis: Theory, method and research*. Sage.

Smith, J. A., Flowers, P., & Larkin, M. (2022). *Interpretative phenomenological analysis: Theory, method and research* (2nd ed.). Sage.

Smith, J. A., & Osborn, M. (2003). Interpretative phenomenological analysis. In J. A. Smith (Ed.), *Qualitative psychology: A practical guide to research methods* (pp. 51–80). Sage.

Sroufe, L. A. (2005). Attachment and development: A prospective, longitudinal study from birth to adulthood. In K. E. Grossmann, K. Grossmann, & E. Waters (Eds.), *Attachment from infancy to adulthood: The major longitudinal studies* (pp. 349–367). Guilford Press.

Stein, A., Woolley, H., Cooper, S. D., Winterbottom, J., & Fairburn, C. G. (2001). An observational study of mothers with eating disorders and their infants. *Journal of Child Psychology and Psychiatry, 42*(6), 733–741.

Stein, A., Woolley, H., Murray, L., Cooper, P., & Fairburn, C. G. (2001b). Influence of psychiatric disorder on the controlling behaviour of mothers with respect to their infants' feeding: A study of women with eating disorders, depression and a healthy comparison group. *British Journal of Psychiatry*, *179*(2), 157–162.

Steiner, J. (1993). *Psychic retreats*. Routledge.

Stern, D. N. (1985). *The interpersonal world of the infant: A view from psychoanalysis and developmental psychology*. Basic Books.

Stern, D. N. (1995). *The motherhood constellation: A unified view of parent–infant psychotherapy*. Basic Books.

Steiner, J. (1993). *Psychic retreats: Pathological organizations in psychotic, neurotic, and borderline patients*. Routledge.

Suchman, N. E., DeCoste, C., Leigh, D., & Borelli, J. (2010). Reflective functioning in mothers with substance use disorders. *Attachment & Human Development, 12*(6), 567–585.

Suchman, N. E., DeCoste, C., Castiglioni, N., Legow, N., & Mayes, L. (2012). The Mothers and Toddlers Program: Preliminary findings from an attachment-based parenting intervention for substance-abusing mothers. *Psychoanalytic Psychology*, *29*(4), 499–517.

Trevarthen, C. (2004). *How infants learn how to mean*. In M. Tokoro & L. Steels (Eds.), *A learning zone of one's own* (pp. 37–69). IOS Press.

Trevarthen, C., & Aitken, K. J. (2001). Infant intersubjectivity: Research, theory, and clinical applications. *Journal of Child Psychology and Psychiatry*, *42*(1), 3–48. https://doi.org/10.1111/1469-7610.00701

Tronick, E. Z. (2007). *The neurobehavioral and social–emotional development of infants and children*. Norton.

Tronick, E. Z., Als, H., Adamson, L., Wise, S., & Brazelton, T. B. (1977). The infant's response to entrapment between contradictory messages in face-to-face interaction. *Journal of the American Academy of Child Psychiatry*, *16*(1), 1–13.

Tronick, E. Z., & Cohn, J. F. (1989). Infant–mother face-to-face interaction: Age and gender differences in coordination and the occurrence of miscoordination. *Child Development*, *60*(1), 85–92.

Trowell, J., & Etchegoyen, A. (2002). The importance of the therapeutic relationship in parent–infant psychotherapy. In J. Trowell & A. Etchegoyen (Eds.), *The importance of fathers: A psychoanalytic re-evaluation* (pp. 157–172). Brunner-Routledge.

van der Kolk, B. A. (2005). Developmental trauma disorder: Toward a rational diagnosis for children with complex trauma histories. *Psychiatric Annals*, *35*(5), 401–408.

van IJzendoorn, M. H., Goldberg, S., Kroonenberg, P. M., & Frenkel, O. J. (1992). The relative effects of maternal and child problems on the quality of attachment: A meta-analysis of attachment in clinical samples. *Child Development*, *63*(4), 840–858.

von Klitzing, K., Simoni, H., & Bürgin, D. (1999). The role of the therapeutic relationship in parent–infant psychotherapy. *Infant Mental Health Journal, 20*(4), 431–445.

Williams, G. (1997). *Internal landscapes and foreign bodies: Eating disorders and other pathologies*. Karnac.

Winnicott, D. W. (1955). The depressive position in normal emotional development. In D. W. Winnicott, *Through paediatrics to psychoanalysis: Collected papers* (pp. 262–277). Routledge.

Winnicott, D. W. (1960). The theory of the parent–infant relationship. *International Journal of Psychoanalysis, 41*, 585–595.

Winnicott, D. W. (1965). *The maturational processes and the facilitating environment*. Hogarth Press.

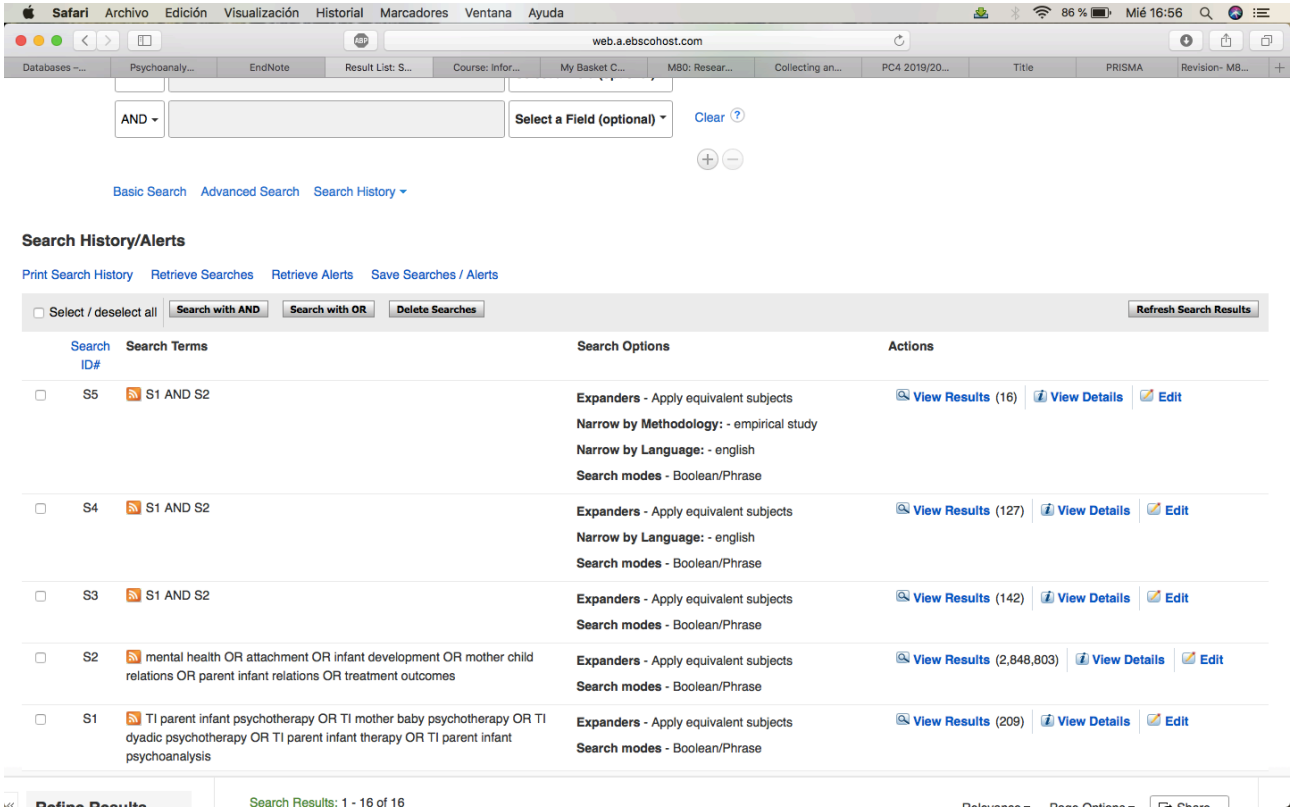
Winnicott, D. W. (1988). *Human nature*. Free Association Books.

Woodhead, J. (2004). Shifting triangles: Images of father in sequences from parent–infant psychotherapy. *Infant Observation,* *7*(1), 1–16. https://doi.org/10.1080/13698030410001708047

ZERO TO THREE. (2016). *Diagnostic classification of mental health and developmental disorders of infancy and early childhood (DC:0–5)*. ZERO TO THREE Press.

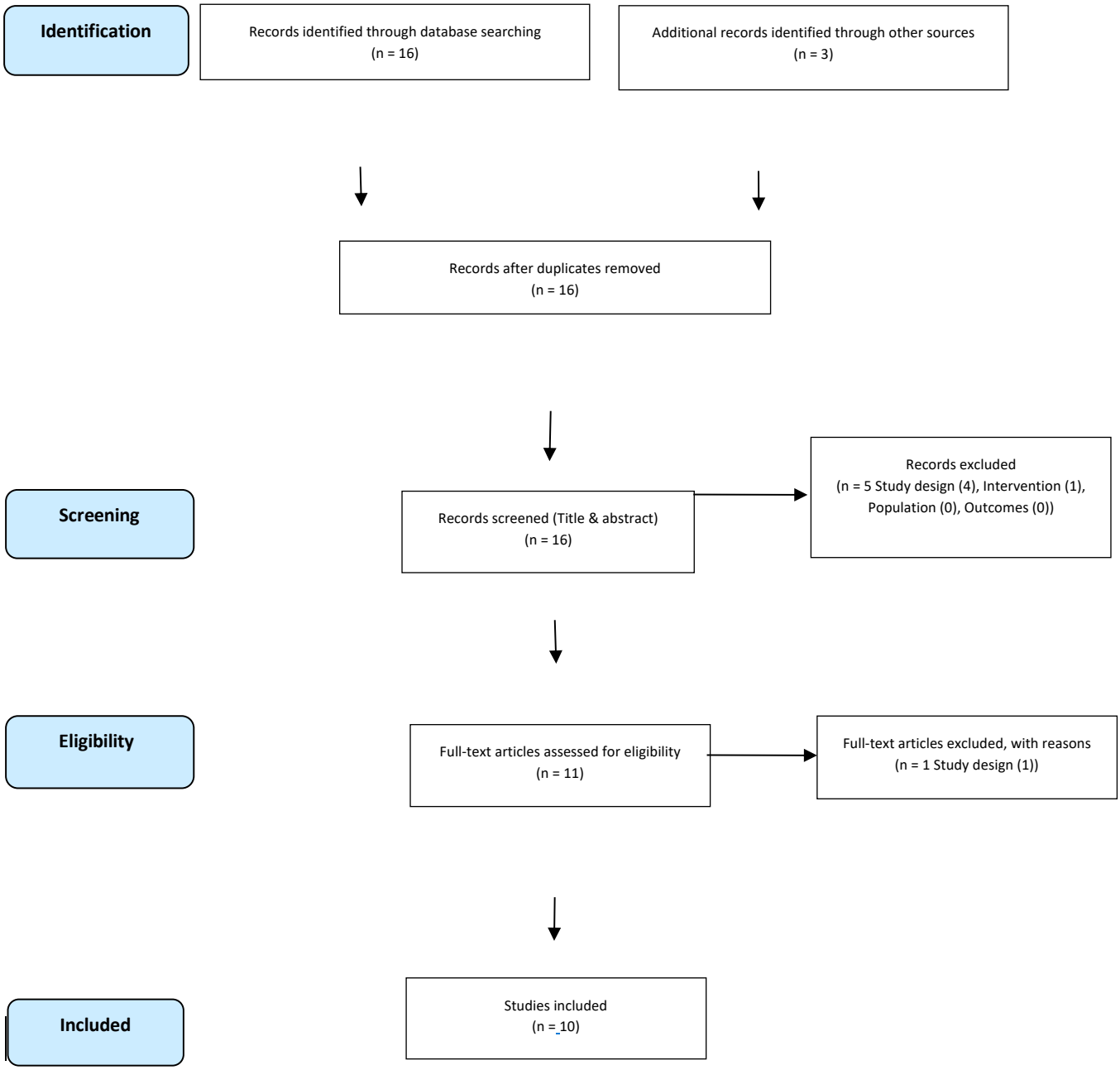
APPENDICES

Appendix A



Appendix B

PRISMA 2009 Flow Diagram



Appendix C

Participant Information Sheet

The Tavistock and Portman
NHS Foundation Trust

Participant Information Sheet

Project Title

What are parents´ experiences of change in parent-infant psychotherapy (PIP)?

What is the purpose of this study?

The present project aims to give parents a voice in understanding how PIP works and how it promotes change that is understood by you, as well as to identify potential areas for future development within the discipline and the local service.

Who is conducting this research?

My name is Rocio Ayala Gonzalez and I am a Child and Adolescent Psychotherapist in Doctoral Training studying at the Tavistock and Portman NHS Trust. I also work for the Perinatal Parent Infant Mental Health Services (PPIMHS) at the North East London Foundation Trust (NELFT). This project is being sponsored and supported by The Tavistock and Portman Centre and has been through all relevant ethical approval (TREC). This course is overseen and certified by The University of Essex.

I have designed the study and will conduct the interviews and data analysis.

What will taking part in the study involve?

You will be invited to take part in an individual interview that will last no longer than 60 minutes. The interview will be audio recorded and is confidential. During the interview we will explore your experience of change in parent infant psychotherapy.

The aim is to conduct a face-to-face interview, however, if this is not possible due to COVID-19, they will take place via telephone or video link at time that is convenient for you.

All participants will be expected to have completed an intervention of PIP.

Are there any benefits to taking part?

It is an opportunity for you to talk freely and reflect on how parent infant psychotherapy has possibly promoted change. This interview is confidential, and your details will not be shared at any point. Your feedback and information will contribute to the development of this area of specialism.

What will happen to the data collected?

Each interview will be recorded and transcribed personally by myself. It will form the data for my doctoral thesis that I am completing as part of my studies. Any distinguishing information from the interviews will be heavily anonymized in order to protect personal details.

Data from the study will be retained, in a secure location, for 3 years. Electronic data will be password protected. All audio recordings will be destroyed after completion of the project.

If you would like more information on the Tavistock and Portman privacy policies, please follow these links:

https://tavistockandportman.nhs.uk/about-us/contact-us/about-this-website/your-privacy/

You can find out more about the legal framework within which your information will be processed by contacting the sponsoring Trust's Clinical Governance and Quality Manager, Irene Henderson: IHenderson@tavi-port.nhs.uk

Disclaimer

There is no obligation to take part in this study and it is your choice whether you decide to be involved. If you do agree to take part, then you can withdraw your data without giving a reason up to three weeks after the interview. If you do decide to withdraw from the research all data collected from you will be permanently destroyed and not used in the data analysis.

Contact Details

Please do not hesitate to contact me if you have questions about the project or would like to discuss anything further.

[redacted]

Email: [redacted]

Address: 120 Belsize Ln, London NW3 5BA

Alternatively, any concerns or further questions can be directed to my supervisor:

[redacted]

Email: [redacted]

If you have any concerns about the conduct of this research, the researcher or any other aspect of this research project please contact Simon Carrington, Head of Academic Governance and Quality Assurance (academicquality@tavi-port.nhs.uk).

Thank you for considering taking part in this study and taking the time to read this information. If you are willing to take part in the research please complete the consent form provided

Appendix D

Participant Consent Form

The Tavistock and Portman
NHS Foundation Trust

Participant Consent Form

Research Project: What are parents´ experiences of change in parent-infant psychotherapy? An interpretative phenomenological study.

Name of Researcher: Rocio Ayala Gonzalez

I confirm that I have read and understood the Participant Information Sheet. I confirm I have been given time to ask any questions I have about the study.	
I understand that participation in this study is voluntary and I am free to withdraw at any time. I understand that I can withdraw my data up to three weeks after my interview.	
I understand that the interview will be recorded, transcribed and analysed for the purposes of the study by the researcher.	
I understand that information I give in the interviews will be anonymized and kept confidential by the researcher.	

I understand that the results of this research will be published as part of a Doctoral Thesis and may form part of future publications or academic presentations with no personally identifying details.	
I understand that I can stop the interview at any point and that I will be offered a chance to debrief after the interview has concluded.	
I confirm that I _____(Participant Name) have understood all of the above and what is required of me and I consent to participate in this study.	

Contact Details:

Researcher: [redacted] Email: [redacted]

Signature: _____

Date: _____

Supervisor : [redacted] Email: [redacted]

Participant's Name (Printed):_____

Participant's Signature:_____ Date:_____

Thank you for agreeing to take part in this study.

Your contribution is very much appreciated

Appendix E

Interview Schedule

The Tavistock and Portman
NHS Foundation Trust

Interview Schedule

What are parents´ experiences of change in parent-infant psychotherapy? An interpretative phenomenological study.

1. What brought you to the PIP Service? Tell me a little bit about what things were like between you and your baby before you came to PIP.

2. What was your experience of Parent Infant Psychotherapy (PIP)?

   -Did you understand what was PIP for?

   -How easy or difficult was it to engage?

   -How did you feel during and in between PIP sessions?

   -Are there specific things you remember or stayed with you from your sessions?

3. What were your expectations/hopes before starting PIP?

   -Were they met/partly met or not met at all?

4. Did you notice any changes in the relationship between you and your child/baby during PIP sessions? If so, please can you say something about this?

-Attunement, relationship/attachment/bond, communication, understanding, confidence in your role as a mother/father?

5. How would you describe the relationship now between you and your baby, following your experience of PIP?

6. What aspects of PIP do you feel made a positive difference (if any) to the relationship between you and your baby?

   -For example: your experience with the therapist. In what ways was he/she helpful or unhelpful?

7. What (if any) were the external factors, not including PIP, that you felt may have contributed to the relationship between you and your baby changing?

   -Changes in the family, in baby's development, financial/extended family circumstances.

8. How would you describe any aspects of PIP that prevented or got in the way of a change?

   -For instance, how you experienced your therapist, your own personal experiences or difficulties, any external factors, health aspects of your baby

9. In the case of parents who dropped out of the PIP treatment process but who want to engage in this interview: What were the key factors that led to you withdrawing early from the PIP process?

10. Is there anything else that you feel would be important to comment on

Additional Information:

This is a draft interview scheduling; it may change based on audit results.

If at any point someone starts to look uncomfortable or show signs that they are finding the interview distressing and/or disturbing, I will pause the interview to ensure the participants' wellbeing and willingness to continue.

Appendix F

Debrief Form

The Tavistock and Portman
NHS Foundation Trust

Dear (Participant name),

Thank you for taking part in my research project.

I am writing to let you know that all information collected during your interview and about you will be stored securely and anonymised to ensure confidentiality. All audio recordings will also be destroyed after completion of the project.

If you have any questions or would like any further information here are my contact details:

Rocio Ayala Gonzalez

[redacted]

If you have any concerns about how the study has been conducted please contact myself, my supervisor Dr Peter Slater ([redacted]) or Beverley Roberts,

Interim Head of Academic Governance and Quality Assurance (academicquality@tavi-port.nhs.uk).

You can also contact our Patient advice and liaison service (PALS) (020 8938 2523) if you have questions or concerns about yourself, or you may need help with something else that is affecting your life. For confidential patient enquiries, you can also use the email address PALS@tavi-port.nhs.uk.

In case you are concerned about your mental health you can contact your GP or local Adult Mental Health Services such as Improving Access to Mental Health Services (IAPT). If you are concerned about your child you can contact your local CAMHS or ask you GP for a referral to their services.

Yours sincerely,

Rocio Ayala Gonzalez

Appendix G

Data Analysis: Exploratory noting and Experiential themes (excerpt from P1 interview)

Exploratory Noting Descriptive Linguistic Conceptual Field Diary		**Experiential Statements (ES)**
	(179)I: it sounds with [redacted] was different, the bonging was, was there? Or was more about understanding him?	
Feeding was secondary to a core issue	(180)P1: The bonding was there, initially, initially it was to help him understand his trauma, making him confident, in playing with other people, talk to other people, come out of the house.	PIFC aimed at helping him understand his trauma, make him confidence, and feel safe to make relational contact, feeding was secondary to that (180)
	(181)I: The feeding was not an issue?	
Understanding him as an individual with his needs and wants, his way of communication	(182)P1: No not at all, feeding wasn't a big part of it, the trauma thing that is how it started off, and then it went onto, led on to understanding him as an individual being with his needs and his wants, and his way of communicating things.	PIFC helped to understand his communication of wishes and needs (182) Behaviour became meaningful (182)
Feeling held by therapist	*(183)I: Was it easy to engage? not initially as you waited for a while... it sounds like you felt you could engage with her...*	Feeling my needs understood as a mother and claimed by therapist (184, 186)
She understood the things I went through. Good understanding of what I needed	(184)P1: yes, and she was keeping on top of everything. Following me up. Your appointment is here, reminder, text messages, to make sure I was attending.	
	(185)I: Was this helpful, keeping track, checking with you?	
	(186)P1: I think a lot of was to do with the fact that she understood the things that I have been through. She had a good understanding of what I needed.	Forever Internalization of therapist stance, something good could be taken in (188)
	(187)I: Are there specific thigs that you remembered or stayed with you from your sessions; words, comments that happened?	Transformational/long life impact of therapist non-reactive stance to anger/aggression (188)
Something staying forever, taking something in, internalizing an stance 'The curiosity stuck' Give him time and space to develop, help himself come our of that He was initially scared Offering space and not pushing	(188)P1: From [redacted] what really stayed, I think for the rest of my life really. It is, I don't know if that is normally, that wasn't even normal for me but the initial reaction to anger, he needs to be stopped, that was not there. No matter what, if he was doing something, she would always wait one second, and then she would intervene. She did not react. There was always that second and the way she would interpret his behaviour. Oh, you are doing this with the block is it because you want to tell mum something, us something. That curiosity. It really	PIFC therapist tried to understand his behaviour with curiosity (188) PIFC therapist gave time and space for the child to develop (188)

Allowing space to explore and let him be vs overwhelming or over worrying, catastrophising Patience and curiosity calm, curious, understanding and contained. Trust and space. Not fixed timeline, aiming to separate in a safe way, overcome trauma of being abandoned or something bad happening Curiosity, freedom with limits and boundaries to be themselves (Wondering if she might be applying what she learnt and internalized from the experience with the new baby) Helped to become a very different boy, used to be shy, cared and intimidated by everything	stuck. Not like how dare you, you have been naughty instead let him explore and be his own individual and following his steps rather than dictating. Like sit here do this or that and in terms of his trauma that we initially came from, give him time and space to kind of develop. Help himself, come out of that. Sort of, initially he was really scared, and she was "let him have his time", she would offer him choice but there was not pushing. That helped me to like, let him, do kind of, let him explore for himself, see what they are going to do with things, rather than going oh my god, they are broken for life. He cannot be fixed. Having that patience and curiosity letting him lead, obviously setting boundaries and limits. *(189)I: It seems you are talking about trusting with time you can work something out, he does not have to be traumatised, over time you can see him developing, but he needing time.* [redacted] *allowing him to take his time, rather than putting pressure.* (190)P1: Yeah exactly, it was not a fixed timeline, but she would say we are going towards you leaving out the room and him staying with me. Play for a little bit, to help him overcome the trauma that he thinks I am not going to come back, and something is going to happen to me. Go out for few min I will be with him. But that did not happen, and she did not push for it. It is hard to explain, you know as a parent that is trying to help me, but I don't know if for other parents that might come out naturally but for me it wasn't. This curiosity, this let him lead, the freedom with limits and boundaries to be.	Mother developed capacity to observe child and wait vs catastrophising (188) Mother trusted and leant from PIFC therapist's stance of curiosity, warmth and patience (188) PIFC brought hope about change (190) Allowing the child to take the time he needs to feel safer and overcome trauma and separation anxiety vs putting pressure (190) PIFC sessions balanced freedom with boundaries to child (190)

Appendix H

Data Analysis: P1 ET List (excerpt)

New self (2)

Wanting to be helpful and accommodating to interviewer' needs (4)

Doing something for the service (4)

Finding out boundaries in interview (8)

Expectation that people don't want to hear difficult feelings/negative experiences (18)

Recording makes things more serious (18)

Difficulty managing demands with little children (20)

PIP and PIFC were with her first son at 3 years old (24)

Understanding takes a long time (26)

Wanting help with what is expected from her, worry about “going off “, overwhelmed or overwhelming others, getting it wrong (26)

Wanting containment (26)

Wanting to contribute/accommodate service’s needs (28)

Sense of “a lot” to share and process, bring up (28)

Feeding problem was ‘part’ of the ‘main thing’ (32)

PIP led to PIFC (32)

DV was experienced as traumatic for mother, and led to physical and emotional difficulties (34, 36)

Baby son affected/impacted by early relational trauma (34)

Maternal mental health difficulties (PND, stress and suicidal thoughts) following DV led to MAU admission (36)

Distress expressed through the body by mother and baby (36)

Interdependence of mother and baby MH (36)

PIP started with severe maternal MH difficulties (36)

Helped/held by continuation of PIP in the community after MAU admission (40)

Maternal depression made it hard to bond (40)

Looking after but not emotionally attached (42)

Maternal Instinct interrupted (42)

missing natural nurturing and protective nature of mother-baby bond, maternal ownership and playfulness (44)

Emotional disconnection from baby (44)

Social media as the new village (44)

Shocking Reality different to expectation of motherhood (44)

Awareness that something was missing and needed help with (44)

Pain and sadness at lack of emotional connection and pleasure with baby: a “brick wall” (46)

Hard to feel, understand and communicate difficult feelings with my son (50)

…

Data Analysis: P1 PETS List (excerpt)

1. EXPERIENCE OF INTERVIEW	
1.1. Motivation to participate and be helpful	
Desire to contribute and be of service	*"whatever is easy for you to remember (4)" "I am here to do this for you (30)," "let me know what you need (28)".*
Identification with other mothers (+P3/P4)	*"if I can help other mothers.... That means a lot" (230)*
1.2. Negotiating boundaries and expectations	
Anxiety about getting it wrong	*"there is a long story so stop me if I am going off (28) "this is probably not what we should talk about... (82)".*
Difficulty expressing negative or complex feelings	*"is going to be recorded... nobody wants to hear the bad things (18)". "I don't know the words, I don't know how to explain that feeling (50)"*
1.3. Emotional labour and managing inner experience	*"Yeah, it is really... reviving the horrible parts... It is a lot that I've buried, and I have to kind of ... bring it back, so it's bringing back a lot (144)"*
2. WHAT LED TO PIP/PIFC?	
2.1. Disrupted maternal bond and emotional disconnection	
Difficult bonding amidst depression	*When I was going through depression, it was really hard to bond with my son. I was going through a lot emotionally and everything else with his dad." (40)*
Absence of natural maternal instinct	*"That natural thing you're supposed to feel — 'oh my god, that's my child, I need to protect him, I want to play with him' — that nurturing nature... I was very poor and sad that I didn't want to be. There was a brick wall between me and him" (44–46)*
Emotional detachment despite practical care	*"I was doing what he needed — food, clothing, looking after him in that sense — but there wasn't any emotional attachment." (42)"Emotionally I was not there for him." (52)*
Loss of maternal identity	*"I was going through a lot... a divorce and all the stuff with his dad, court cases because he wanted to see his son. So, I was more focused on those*

	things. I never had that feeling of being a mum." (54)
2.2. Impact of trauma and maternal mental health	
Postnatal depression and traumatic experiences	*"After he was born, I went through domestic violence... He was only three months old when I left his dad. Because of the trauma, I became very unwell — physically and emotionally. I was very stressed, went through postnatal depression, developed physical symptoms, weakness in my leg... and then suicidal thoughts. They sent me to the MAU." (34–36)*
Sense of failure, guilt and perceived inadequacy	*There was a lot of guilt that I had. That I was not able to be a happy mum (68)* *I was a rubbish mum, I felt so guilty. I am not able to do things that all these people are doing (72)*
Helplessness and lack of control	*"Like, why is this all happening to me?" (68)* *"I felt so helpless; I could not be there for my son" (124)*
Isolation and disconnection from support systems	*"And then it was COVID, it was lockdown. I was just in the hospital. We couldn't go out, no one could visit." (56)* *"At MBU the doctors were good, but they'd only see you for an hour a day. Some of the nurses... most of them were awful." (64)*
Somatic expression of emotional distress	*I was very stressed, went through postnatal depression, developed physical symptoms, weakness in my leg...(36)*
2.3. Discrepancy between idealised and real motherhood	
Conflict between expectations and reality	*"You know how you see on social media how you're supposed to feel... that natural thing — I wasn't that." (44)*
Striving for happiness despite internal strugges	*"Yeah, I wanted to be a happy mum." (70)*
2.4. Son's early relational trauma and distress	
Emotional and developmental impact on the child	*"He ended up with big trauma — he's scared of everyone, doesn't go out, cries in his sleep, he's terrified. He was through a sort of depression." (120)*

	"He was mentally very disturbed and traumatized — had PTSD or whatever he had — and at that point I had nobody to reach out to." (136)
Shared emotional experience between mother and son	*"He went through a lot with his dad too; he was only three months old when I left his dad." (34)* *"He was really traumatized... at the contact centre they literally snatched him from me and gave him to his dad. He'd never seen his dad, he cried the whole hour and vomited every session. They wouldn't give him back to me." (156)*
3. HOPES AND EXPECTATIONS FOR PIP/PIFC	
3.1. Seeking recovery and a sense of normality	
PIFC as a pathway to regain normal life	*"My son needed a lot of help... to get back to normal." (144)* *"I needed from the service, so the feeding, and the big trauma that he ended up with — I need somebody to help sort that out for him so he can start going into nursery." (120)*
Urgency to repair and undo damage	*"It was a lot for my son, he was really traumatised. So that was the things I wanted to work with... To help him get rid of this trauma." (118)* *"I don't want to be the word normal but all these horrible stories he's gone through — it's going to fix it." (144)* *"It's helping me somehow, cause we are going to come out with a solution or we are going to come up with something." (156)*
Continuing the bonding journey	*"A lot of the other stuff that kind of had to be carried over from M's PIP sessions and my working with her... by the time that I met with PIFC... the bonding had started to form with my son from the working I've done with M (PIP). So, they were not as bad as when I started working with her. When I started seeing PIFC therapist, it was the feeding and all other issues" (118)*
3.2. Navigating the transition from PIP to PIFC: From continue to disruption	
Difficult ending and the impact of waiting	*The PIFC assessment felt impersonal and unhelpful." (160, 162)*

	"There was a year gap… from the assessment to treatment, it felt like abandonment." (122) *"Having to wait from assessment to treatment was unhelpful." (118)* *"Waiting for PIFC impacted negatively my mental health." (118) "I felt helpless and unsupported during the transition." (122, 124)*
Continuity of care as a lifeline	*"Continuity of care from inpatient M&U to community PIP saved me — it held me." (72)* *"PIP after admission made it possible to engage with PIFC later." (40) "Holding onto previous experiences of PIP support facilitated PIFC engagement." (208)*
Feeling lost and needing to be found	*"I needed someone to find me, to keep the link." (132) "When you are depressed, you don't have the energy to ask for help — you need someone to reach out." (130) "It felt like internal and external failure — not being looked after well at the MAU, not able to look after my baby." (60, 64)*
PIP and PIFC differentiation	*"with M.. she was helping with my own trauma, that kind of thing, it helped me with my trauma and my bonding with my son but now because of the contact centre and my son, now he was left in a mess" (136)* *"The PIP and PIFC sessions were very different. Maybe because we were doing different things. PIFC's sessions were mainly focused on my son." (166) PIFC was to help him understand his trauma, making him confident, in playing with other people, talk to other people, come out of the house (180)*
3.3. <u>Transforming expectations: from disappointment to hope</u>	
Navigating initial misunderstanding and dissatisfaction	*"There were misunderstandings with the transition from PIP to PIFC… not helpful"(208)* *"The PIFC assessment didn't feel personal — I felt unseen at first." (160, 162)*
Perseverance despite disappointment	*"It was the thing, the fire I had inside in me that I wanted my son to get better, seeing him like that was horrible, nobody should see a child like that. We could not even go to somebody's house, and he would scream, stay outside. I wanted to help*

	him that was a big thing. Second part of it, having done the work with PIP therapist, I knew that once I get somewhere it is going to be good, it is going to help me. Everything she done to me I still held on, maybe if I hadn't had that experience, I will be this is a waste of time, pointless, I can't be helped. (208)
Expectations met in unexpected ways	*"Hopes were met; expectations were different. But that was not a bad thing… I expected sessions to start sooner, even though it was once a week, it turned out to be for good, because that year his needs changed." (198)*
3.4. <u>Emerging hopes and transformation</u>	
Relief and renewal through PIFC	*"There was a sense of crisis, urgency — but when PIFC started, it offered consistent support for me and my son." (150)* *"PIFC brought hope about change." (190)*
Recovery through relationship	*PIFC was transformational for my son." (168)* *"It helped us to connect and face reality in the context of trauma." (150) "PIP/PIFC gave me space to talk openly and not feel judged." (230)*
A journey of continuity and growth	*"PIFC brought hope in recovery from trauma… I've gained a lot from PIP and PIFC." (200, 228)*

Appendix I

GETS: Mapping and clustering



GETs: Process of Developing the Final GETs with Participant Quotes (Excerpt)

A. What Led to PIFC	Text Quotes
Entering PIFC through early feeding-related crisis and urgency	P1: 118, 196, 110, 118, 32, 124, 68, 200 P2: 7, 9, 83, 21, 120, 196 P3: 10, 12, 30 P4: 48, 2, 4, 48
Disruption of maternal confidence and instinct, emotional regulation, and felt connection with the infant	P1:4, 44, 46, 36, 2, 54, 68, 72 P2: P3: 6, 10 P4:2
Early trauma and medicalisation shaping the present	P1: 120, 136, 118, 34, 156, 34, 36 P2: 23, 69, 67, 65 P3: 2, 8, 4, 10, 23 P4: 2, 44, 20

B. Mothers' Experience of Change in Their Infants	
From Distress to Relief – Noticing That Something Is Improving	P1: P2: 13,46, 59, 33. P3: 34, 16 P4: 40, 36, 10
Experiencing the Infant as More Regulated, Communicative, and safe in relationships:	P1: 168, 196, 198, 196, 202 P2: 19, 32, 99, 63, 95, 31 P3: 34 P4:
C. Mothers' Experience of Change in Themselves	
Feeling More Contained, Supported, and Emotionally Regulated	P1: 150, 184, 200, 202, 204, 214,228, 176, 72, 92, 68, 96,106, 136, 92 P2: 35 P3: 18, 32, 48, 2, 16, 22, 38, 44, 30 P4:56, 30, 52
Restoring Confidence, Maternal Instinct, and felt connection	P1:200, 202, 226, 206 P2:65, 71, 85, 89, 78, 79, 61, 35, 85, 101, 103, 61 P3: 22, 16, 26 P4:
Making Sense of Motherhood: Shifts in Perspective and Parental Authority	P1: 206, 84, 92, 76, 78, 84, 228 P2: 21, 31, 39, 79, 101, 85, 41, 71 P3: 32, 34, 46, 30, 22, 26, 18, 30, 16 P4:20, 76, 50, 56, 52, 24, 28, 26, 48

Final Group Experiential Themes (GETS)

A. What led to PIFC

- Early feeding-related crisis and urgency
- Early trauma and medicalisation shaping the present
- Disruption of maternal role, emotional regulation, and felt connection with the infant

B. Mothers' experience of change in their infants

- From distress to relief – noticing that something is improving
- Experiencing the infant as more regulated, communicative, and safer in relationships

C. Mothers' experience of change in themselves

- Feeling more contained and supported
- Restoring confidence and maternal instinct
- Shifts in perspective and maternal authority

D. Change in the mother-infant relationship

- Moving from reactivity to greater curiosity
- Experiencing greater emotional closeness while allowing separation and autonomy

E. New understanding of feeding and weaning in light of change

- Feeding as a source of confusion and disruption
- Reframing feeding difficulties as meaningful

F. Engagement with PIFC: expectations, facilitators, and barriers

- Expectations of rapid repair versus hopes for understanding
- Personal and systemic barriers to engagement
- Trust, continuity, and relationship as facilitators of engagement

Appendix J

Ethical Approval

The Tavistock and Portman
NHS Foundation Trust

Quality Assurance & Enhancement
Directorate of Education & Training
Tavistock Centre
120 Belsize Lane
London
NW3 5BA
Tel: 020 8938 2699
https://tavistockandportman.nhs.uk/

Rocio Ayala Gonzalez

By Email
27 July 2023

Dear Rocio,

Re: TREC Application - Minor Amendments

Title: 'Mothers' Experiences of Change in Parent-Infant Psychotherapy for Infants with Feeding Difficulties: An Interpretative Phenomenological Analysis'

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

Please note that any changes to the project design including changes to methodology/data collection etc, must be referred to TREC as failure to do so, may result in a report of academic and/or research misconduct.

For information governance purposes and in line with the Trust policies, please be advised that in order to conduct research/interviews using online video conferencing you must contact TEL team (telsupport@tavi-port.nhs.uk) to set up a zoom account.

With regards to privacy, please ensure that meetings with yourself and your participants are conducting in a safe environment and that confidentiality is maintained.

Your updated TREC form is attached.

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

Michael Franklyn (he/him)
Academic Governance and Quality Officer
Tavistock and Portman NHS Foundation Trust
mfranklyn@tavi-port.nhs.uk

cc. Course Lead, Supervisor, Research Lead