

**Experiences of parent-infant teams among mothers
diagnosed with perinatal mental health difficulties**

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Abstract

Background: Disrupted parent-infant bonds can have a negative impact on childhood development. In the United Kingdom, parent-infant teams consisting of mental health professionals with expertise in infant development and parental mental health, can offer support to parents (most commonly mothers) to help strengthen parent-infant relationships. However, little is known about women's experiences of these teams. This study aimed to explore experiences of support from parent-infant teams among mothers diagnosed with perinatal mental health difficulties.

Method: Semi-structured interviews were conducted with eleven mothers in England who had had been referred to and/or accessed a National Health System parent-infant team. Qualitative interviews were analysed using thematic analysis.

Results: Women reported occasional difficulties accessing parent-infant services, particularly when they were left to contact services or follow up referrals themselves. However, once accessed mothers valued consistent, regular support with a therapist who was empathic and accepting of their difficult feelings. Some women saw therapists as resembling 'mother figures' and appreciated a feeling of being cared for. However, at times women felt there was an overemphasis on the role of the mother and mother-infant bond, and a disregard of fathers and other family members.

Conclusion: Our study demonstrates that mothers value support from parent-infant teams. However, clinicians need to ensure they do not inadvertently reinforce problematic gender norms when offering support (e.g., around what it means to be a 'good mother'): they should give more consideration to fathers, partners and family members and challenge wider social structures and narratives that may contribute to women's difficulties.

Keywords: parental bond, postnatal care, perinatal mental health, parent infant teams, qualitative

Word count: 3715

Introduction

Research suggests that early caregiving experiences and a strong parent-child bond are vital to children's development and later life experiences (de Cock et al., 2017; Bernier et al., 2010). Positive early parent-infant interactions and a secure attachment with a primary caregiver are believed to lay the foundation for a child's future interactions, wellbeing and behaviours (Bowlby, 1969; Ranson & Urichuk, 2008). The perinatal period, from pregnancy to one year postnatally, is increasingly seen as a critical time for infant development. Most research into parent-infant bonding has focused on the mother-infant bond. It has been argued that key components of an optimal mother-infant bond include, among other things, 'maternal sensitivity' (the capacity to observe and interpret the child's signals and respond appropriately; Dean, 2020) and 'reflective functioning' (a mother's capacity to understand her own and her infant's internal mental states and how these are influenced by interactions between them; Slade, 2005). Lower levels of 'maternal sensitivity' and 'reflective functioning' have been associated with poorer outcomes for infants (Deans, 2020; Slade, 2005). Parents who struggle to bond with their babies also report high levels of distress (Reck et al., 2016; de Cock et al., 2017). There is growing recognition of the importance of the father-infant bond too (Sethna et al., 2015), however it is conspicuous that mothers remain the main focus of research and continue to be seen across many societies as bearing the greatest responsibility for infants' development (Bowlby, 1969; Deans, 2020). This may add to the pressure felt by mothers to bond with their babies.

Parent-infant teams in the UK aim to support the developing parent-infant bond, where this is considered problematic. These teams are typically made up of child psychotherapists and psychologists, as well as other practitioners such as specialist health visitors, often (although not exclusively) working within the context of parental mental health difficulties. They work dyadically, with one parent and their baby (as well as triadically, with two parents and their baby, or in a group) in the community, offering a range of therapeutic interventions, of varying durations, that aim to support parents who are struggling to bond with their babies typically up to a year following birth, and sometimes also in pregnancy. There is local variation in how these teams are commissioned and constituted, and with regards to the interventions they offer (Parent-Infant Foundation, 2020).

A recent report by the Parent Infant Partnership UK (Parent-Infant Foundation, 2020) found that there are currently only 34 parent-infant teams across the UK, leaving most babies and parents in areas without this type of support. However, recent policy initiatives in the UK, such as the First 1000 Days of Life report (Health and Social Care Committee, 2019) and the NHS Long Term plan (2019), have advocated for greater focus on interventions that support the parent-infant bond, particularly in the context of perinatal mental health difficulties.

Despite this, while approaches such as video feedback have shown some promise in the perinatal period (O'Hara et al., 2019), evidence for the effectiveness of parent-infant services is limited. A systematic review (Barlow et al., 2015) of psychoanalytically informed parent-infant psychotherapy found that, while parent-infant psychotherapy significantly improved attachment security in high-risk families, there was no evidence for its impact on other outcomes, such as parent-infant interaction (maternal sensitivity) or parental depression. The authors noted, however, that rigorous evaluation was problematic due to significant variation in the types of intervention evaluated, little consistency in the outcomes measured, and low quality of evidence. A small mixed-method study of a parent infant mental health attachment project for 'edge of care' families (i.e., families with significant child protection concerns) in the UK (McPherson et al., 2018) found that parent-infant therapy was effective in keeping 85% of families together (compared with an estimated 50% nationwide), and that mothers' warmth towards their infants appeared to improve post-intervention, with clinicians delivering the intervention also perceiving it to be valuable. To our knowledge, little is known about mothers' own experiences of parent-infant teams and whether or not they believe these teams support their needs effectively.

Consequently, this research aimed to explore the views of mothers diagnosed with perinatal mental health difficulties who received support from a parent-infant team in order to inform future clinical practice and policy.

Method

This study was part of a larger qualitative interview study (Stakeholders' Views and Experiences of Perinatal Mental Health Care; STACEY), which investigated experiences of a range of services across

England accessed by women diagnosed with perinatal mental health difficulties (see e.g., Lever Taylor et al, 2019; Lever Taylor et al., 2020; Zacharia et al., 2020). The study took a broadly critical realist perspective (Vincent & O'Mahoney, 2018), focussing on understanding women's lived experiences of pregnancy and early motherhood, the services they received, and the interface between the two. It therefore aimed to inform research and practice on perinatal mental health services by understanding these services through the lens of recipient women's experiences.

Participants

In total, 52 women were recruited for the STACEY study by clinicians in NHS mental health services. Clinicians within relevant services approached eligible women in their service and then informed researchers of women who were interested in participating in the study. The research team then called these women to provide more information. Women also received an information sheet by email (or post if email was not possible). As women had sometimes accessed more than one service, it was not always a parent-infant team clinician who initially approached them. Women taking part had to speak English; be 16 or over, have a baby aged 6-9 months; and have accessed NHS support for their perinatal mental health. Eleven mothers from this wider sample were included in the current study because they all described having been referred to and/or accessed a parent-infant team in their interview. Included teams were dedicated NHS services that offered therapeutic support to the parent and infant together, focusing on the parent-infant relationship. Data relating to parent-infant teams was extracted and analysed in the interviews with these women.

Data Collection

Interviews were conducted between October 2015 and March 2017. A semi-structured interview guide was developed by the study team and adapted after feedback from a perinatal service user advisory panel. The guide included questions regarding women's experiences of accessing and using services (e.g. how did you find the process of accessing support or treatment? Can you describe your experiences of the service/support you received?). Interviews lasted around one hour. The eleven interviews were carried out by the main researcher (who is a mother, researcher and clinical

psychologist but did not work in a parent-infant team and was not involved in the care of any participating women), except in one case where the interview was conducted by a mental health Masters student (under the main researcher's supervision). Interviews were conducted face-to-face with women, usually in their own homes. NHS ethics approval (13/LO/1855) was obtained, and women provided written informed consent.

Analysis

Interviews were audio-recorded, transcribed, anonymised and imported to QSR NVivo 11. The first author (a Masters student studying Clinical Mental Health Sciences) coded the data using thematic analysis, (Braun & Clarke, 2006), adopting a predominantly inductive data-driven approach. Initially, each interview was read and re-read to identify relevant sections, which were then coded in detail. Relationships between codes were explored, looking at similarities and differences, and organised into themes or subthemes in an iterative process. A second researcher reviewed three of the transcripts independently to enhance rigour. Any disagreements between researchers were discussed whilst referring to original transcript data, and resolved by coming to an overall consensus.

In qualitative research, it is considered important to reflect on the role of researchers and how their own experiences, backgrounds and knowledge may impact expectations, assumptions, and interpretations of the data. The whole research team were female and white, two were clinicians, and some had experiences of motherhood. A reflexive stance was taken throughout data analysis to consider how these (and other) researcher characteristics may have played a role in shaping interpretations of the data.

Results

Demographics

The eleven included mothers were from London and the South of England (see Table 1). Over two thirds were White British ($n = 8$) with a mean age of 30 (range 20-39). Most self-reported a primary diagnosis of a personality disorder ($n = 5$), or (post-natal) depression ($n = 5$); the other participant had a diagnosis of psychosis ($n = 1$). One mother had been referred to a parent-infant team but had never

seen them, while the others had all accessed support from a variety of NHS parent-infant teams. It should be noted that many of the women described living in difficult scenarios (e.g. experiencing significant relationship conflict or breakdown). Four had significant social services involvement while one did not have custody of her baby.

[Insert Table 1 here]

Thematic analysis

We identified three key themes: empathy and a ‘motherly’ role-model; accessible and consistent support; and exclusion of partners, fathers and family.

Context: wider challenges in motherhood

Many of the women included in our analysis described experiencing difficult life circumstances which not only made bonding with the baby difficult, but led to feelings of guilt and fears of having their babies taken away from them. Some women reported struggling to bond with their baby in the context of relationship conflict with partners or other family members, and a lack of social support. Others connected their current experiences and struggles to past difficulties in their own experiences of care from their parents.

Several women had also experienced traumatic births and/or premature babies, with two women in particular connecting their bonding difficulties to this. These wider challenges influenced women’s experiences and interactions with services.

Empathy and a ‘motherly’ role-model

Women found their difficult feelings towards motherhood and their babies distressing, and in some cases hard to make sense of. In this context, having a clinician who could establish a strong relationship with them appeared vital. Trust allowed mothers to feel comfortable discussing their bonding difficulties and admitting to their motherhood struggles. Occasionally however, women struggled when therapists were perceived as less warm or even ‘icy’. To trust their clinician, women

emphasised that professionals needed to be non-judgemental, accepting of their difficult feelings, unpatronizing and ‘on side’, especially because of the guilt experienced by mothers, feelings that others were judging them and anxieties about social services involvement.

Say for instance, if [my baby’s] had a bad night, I could feel like I could say to [my parent-infant therapist], ‘Oh she was up most of the night, yes it was a bit stressful but I’ve dealt with it. But I did feel that at some points I wanted to feel agitated or a bit wound up and wanting to scream and shout’...But where with my social worker I feel that I can’t say nothing like that ...I’ve not felt that [my parent-infant therapist has] spoken down to me...I feel she sort of understands what I’m saying and where I’m coming from. [Mother 10]

Some women who had positive experiences perceived their therapist as in some ways resembling a friend. In other cases, women likened parent-infant therapists to ‘mother-figures’, linking this to them being loving, caring, soft-natured and calm. This appeared in part to reflect a desire on women’s part to feel cared for, understood and mothered themselves, or “looked after” by someone who “could read my situation, read me, and know” (Mother 4). Mothers also saw therapists in some respects as role models who they sought to emulate. However, it was conspicuous that, on occasion, women seemed to describe a rather idealised narrative of how a ‘proper mother’ should be. This could potentially contribute to them feeling inadequate because of their ambivalent or angry feelings towards their babies, or their emotional distress in the context of the challenges they faced. There was therefore also some complexity apparent in the role of parent-infant teams: in some respects, a perception of therapists as motherly figures who taught women to be more sensitive - or ‘better mothers’ - could end up reinforcing problematic gender norms (i.e. that a ‘good mother’ was gentle, not angry, and loving, not ambivalent).

[My parent-infant therapist is] very motherly. I think she’s everything that I would picture a proper mother to be actually. That’s probably the best way to describe her...Just nice, calm, loving. She’s just so soft-natured. [Mother 9]

At the same time, women appreciated clinicians giving them “guidance”, “reassurance” [Mother 10] and positive feedback, as well as normalising their feelings.

It was a lovely way of saying it, 'you seem delighted with each other' ...And because I constantly question whether I'm a good mother or not, and question whether she feels secure and safe with me, and loved by me, all of that stuff, to have somebody, a professional, say, yes, they do, and yes, you have that. That was great, actually. [Mother 4]

Furthermore, the idea that the therapist would offer another perspective, including the perspective of the baby, was valued because it allowed women to evaluate their experiences differently. Where it was offered, video-feedback therapy, in which mothers received direct feedback from a parent-infant therapist on their interactions with their babies, was reported to be beneficial. Specifically, women valued looking back on video-recordings, hearing their therapist's observations, and reflecting on their interactions with their babies from a different perspective. Women felt this allowed them to see their interactions with their child from 'outside', see their infant's viewpoint, and develop a better understanding of their dyadic bond. This feedback was subsequently perceived to help strengthen the mother's bond with their infant:

Just looking back at the video and [the parent-infant therapist's] feedback and trying to get you to interact with what you think you see in the image.

...She helped me connect, so I have a really big appreciation for her. [Mother 6]

Accessible and consistent parent-infant support

Aspects of service delivery also contributed to or hindered the development of the therapeutic relationship. In particular, the need for an accessible, consistent and adaptable service was emphasised. For example, one parent-infant team offered home visits, and this was highly valued as attending appointments out of the home could be difficult:

[My parent-infant therapist] has come here. I mean I was attacked a couple of months ago now and I didn't want to go out. And so she came over...So she is very flexible. [Mother 14]

Contrastingly, when support from a parent-infant team was not frequent or consistent enough, women could struggle to maintain their progress.

At the time I think so much was going on that I think just that kind of one hour a week maybe wasn't enough...it just became more difficult. [Mother 2].

Women preferred regular support within a consistent environment and disliked it when parent-infant teams had limited flexibility. This was particularly important considering women would often attend sessions with their babies.

It's never like every week, or every two weeks. It's more like, she looks to see when she's got a free spot and then we book it in...

... Yes, the room changes all the time, so booking of rooms, whatever, and finding somewhere to go. So you're in different rooms and not always in an environment... You're not always sat in an environment that's particularly comfortable or cosy or relaxing. [Mother 4]

Whilst the majority of women had few issues accessing parent-infant teams, some women did find accessibility a problem. Specifically, some women, including the woman who had been referred for parent-infant support but had not accessed this, reported that after a referral had been made, they were sometimes required to follow this up themselves. This could prove difficult, for example due to anxieties about accessing support and potentially attracting social services involvement, or if they were uncertain what parent-infant teams were or how to contact them.

Exclusion of fathers, partners and family

Some women felt that the mother-infant bond was prioritised by their parent-infant team and the father-infant bond was not commonly the focus of treatment. Some felt that parent-infant teams marginalised fathers.

I don't think they tried to help him [the father] enough. [Mother 10]

This could be problematic and could reinforce women's feelings of pressure and responsibility to be the primary caregiver, contributing to their difficulties. For example, one woman believed that her difficulties were predominantly related to struggles with her partner and the unequal roles between them. The parent-infant team, however, focussed on her bond with her baby with little consideration of these wider relationship inequalities, not involving the father in support, or considering the couple. The mother meanwhile feared that, if she were to bring up worries outside of her own bond with her baby, support might be withdrawn because her difficulties might then be considered out of the scope of the service.

*I really struggled with my partner because...it was always like [our baby would] cry and I'd be the one that gets up with her...almost like sub-consciously it's my job to do that...
...I feel like him and I need some counselling together. But again, I don't know if that's crossing into a different area...
... I need to remember to keep talking about any problems I'm having directly related to [my baby]. Because I'm concerned that if I'm not talking about those as much, then the service might be taken from me." [Mother 4]*

In another case, a woman reported that, whilst the parent-infant team had provided some one-to-one support antenatally to her partner around his thoughts and feelings about the pregnancy and fatherhood, the service failed to help them with their relationship issues due to a lack of training.

'And the [parent-infant] lady, she said like, 'So I'm not trained in couple's therapy. I can't help you with that'. And I was not really into her.' [Mother 1]

Women however also recognised that fathers were not always willing to cooperate or attend services. This was attributed to not being involved with the child or not feeling like support was needed. One woman noted though that, while her partner had been unwilling to attend support, she also felt clinicians had not made enough attempt to encourage him to do so. Ensuring women's own needs were not neglected or marginalised by increased family involvement, particularly given many of these women were living in complex and sometimes abusive relationships, appeared vital. However, there was a balance to be found, with women reporting that services did not usually involve fathers, partners or wider family members, and nor did they always consider alternative family set ups.

Just because it's biological, doesn't make him any less a father. So stop acting like he's just a tagger-onner. And he's just my partner. No he's not. He's her dad.' [Mother 14]

Discussion

This study explored women's views of support from parent-infant teams. Findings suggest that women had positive experiences of parent-infant services when support was flexible, consistent, regular and accessible. Women valued feeling cared for by an empathic therapist who reassured them, provided feedback and an alternative perspective, and accepted their difficult feelings.

Our research has similarities to an Australian study of women who accessed a specialist perinatal and infant mental health service (Myors, Schmeid, Johnson, Cleary, 2014). As in our study, while women sometimes found the process of accessing support difficult, relationships with clinicians were seen as key, with women reporting very positive experiences when clinicians were seen as ‘there for’ them and as reliable, consistent and flexible.

In our study, some women described therapists as mother figures, who they felt cared for them and who they sought to emulate and learn how to be a ‘good mother’ from. This also has similarities to Myor et al.’s (2014) research which highlighted the importance of clinicians modelling a secure base which mothers could emulate. However, whilst women in our study could find this nurturing and comforting, in the context of these women’s often difficult wider social circumstances, the findings emphasise a need to also ensure the role of parent-infant teams does not end up upholding problematic discourses around the ‘good’ or ‘perfect’ mother. This supports the findings of a meta-synthesis of post-partum depression which emphasised how healthcare professionals may unwittingly reinforce cultural ideals of the ‘good mother’ and should include in their work a focus on broadening and challenging narratives around how motherhood is constructed (Knudson-Martin & Siverstein, 2009). This is especially important given that parent-infant teams were also seen by women as prioritising the mother-infant bond while neglecting to fully involve or consider fathers, partners, father-infant bonds, couple relationships or the wider family.

Our previous research has found that other services treating perinatal mental health difficulties similarly tend to focus on mothers and infants, with fathers and wider family members left feeling marginalised (Lever Taylor et al., 2019). While it is important that family involvement does not result in deprioritising women’s needs, it appears vital for services to find an appropriate balance. Future research may also benefit from exploring fathers’ and family members’ views of parent-infant teams.

Strengths and limitations

While this study offers novel findings, it also had limitations. The small sample size, made up predominately of white women, means the findings may not reflect the views of all mothers. Whilst

this may reflect the fact that women from ethnic minority backgrounds are less likely to be detected or treated in perinatal services (Prady et al., 2016), incorporation of a more diverse group of women may have provide insights into understanding barriers to access. Furthermore, it would have been valuable to include more women who struggled to bond with their baby but did not access support. It should also be noted that clinicians helped recruit women which may have meant those who engaged better were more likely to participate.

Furthermore, the women were recruited from a larger sample which meant a range of services were discussed in interviews. A more comprehensive understanding of parent-infant teams, including more specific comments on the types of support they offer, may have been achieved if interviews were based primarily on this topic area. The study did attempt to overcome this issue by probing mothers to go into detail about each service, but it was apparent during interviews that some women wanted to discuss other services in more detail.

Nevertheless, a strength is that this is the first piece of published research to provide participant-driven accounts of experiences of parent-infant teams in the UK. Research that explores women's lived experiences of service support can enable women's voices to inform service developments and improvements.

Conclusion

Overall, mothers valued consistent, regular, accessible support from parent-infant teams, where clinicians established strong therapeutic relationships with them characterised by trust, non-judgement and acceptance. This was especially important given many women had a history of trauma and abandonment in their lives. Services need to ensure, however, that fathers and other family members are considered, and that they do not contribute to reinforcing problematic gender norms. Developing and evaluating family therapy interventions may be of benefit, as well as ensuring professionals are supported to acknowledge and challenge gender and cultural constructions around parenting.

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Table 1: Demographic and clinical characteristics of interview participants

Participant characteristics	<i>n</i>
Age (years)	
≤ 25	4
26-30	3
31-35	1
36-40	3
Ethnicity	
White British	8
White Other	1
Black Caribbean	2
Location	
London	5
South of England	6
Primary diagnosis	
Depression	5

Personality Disorder	5
Psychosis	1
Highest education level	
Degree or further education	4
A Levels/equivalent	4
GCSE*/equivalent or less	3
Marital status – N (%)	
Living with partner/husband	7
Not living with partner/husband	4
Number of Children	
1	6
2	3
3+	2
Mothers with child protection concerns	
Child protection plan/team around child	4
Loss of Custody	1
Parenting assessment	1
None	5

* General Certificate of Secondary Education