

**Mothers' experience of therapeutic processes in a reflective parenting programme**

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**Thesis declaration form**

I confirm that the work presented in this thesis is my own. Where information has been derived from other sources, I confirm that this has been indicated in the thesis.

Signature:

Name: Phebe Burns

Date: September 2014

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## Overview

This thesis focuses on early parenting interventions that aim to promote secure parent-child attachment relationships.

Part 1 is a literature review that critically evaluates the evidence for the effectiveness of early parenting interventions in improving the maternal sensitivity of mothers with clinical problems. Twelve studies met the criteria for inclusion; the methodological quality of the studies was high. Mixed evidence was found for the effectiveness of these interventions on maternal sensitivity, particularly in depressed mothers. Further research examining the long-term impact of these interventions on maternal sensitivity in clinical populations and their effectiveness with different types of psychological difficulties is needed.

Part 2 is a qualitative study exploring parents' experiences of engagement and change in Minding the Baby (MTB), a parenting programme aimed at facilitating improvements in the reflective functioning of disadvantaged mothers. The study is part of a larger UK pilot study of the MTB programme and it was conducted in collaboration with another UCL Clinical Psychology Doctorate student (Grayton, 2014). In the study, semi-structured interviews were conducted with 16 mothers and three fathers currently participating in MTB. Parents described changes in their parenting skills, their confidence and their wellbeing. They valued the flexible, individualised and collaborative nature of the programme and the strong therapeutic relationships they had with their MTB practitioners. The findings suggest that tailoring parenting programmes to meet the specific needs of parents experiencing social adversity is particularly important in facilitating their engagement and change.

Part 3 reflects on challenges in designing and conducting the qualitative study, and the ways in which these were addressed.

## **Acknowledgements**

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**Part 1: Literature review**

**The effectiveness of early parenting interventions on maternal sensitivity in clinical populations**

## **Abstract**

**Aims:** Psychological difficulties in mothers, such as depression, can have a negative impact on the mother-infant relationship, and therefore impede the social and emotional development of the child. Maternal sensitivity is an essential aspect of the mother-infant relationship and can be improved through early parenting programs. This review aimed to critically evaluate the evidence for the effectiveness of early parenting interventions in improving the maternal sensitivity of mothers with clinical problems.

**Method:** Studies were identified from a search of the PsychINFO, Medline and EMBASE online databases. Only controlled experimental designs (randomised or non-randomised) were included. Studies were rated for methodological quality using a checklist developed by Downs and Black (1998).

**Results:** Twelve studies met the inclusion criteria for the review. With the exception of two, all of the interventions studied aimed to support the mother in identifying and interpreting her infant's cues and tailoring her responses to match the infant's needs. Interventions were administered through home visits (eight studies) or groups (four studies) and the majority of the studies (11) examined mothers with depression. Nine studies used a randomised design; studies varied in terms of the type of control group and their outcome measures. Seven studies reported improvements in maternal sensitivity following intervention.

**Conclusions:** Overall, this review provides mixed evidence for the effectiveness of early parenting interventions on maternal sensitivity in mothers with clinical difficulties, particularly depression. Further research is needed to examine interventions with different types of clinical problems, and in relation to that, the suitability of particular interventions for specific populations. It is also important to examine the long-term impact of interventions on maternal sensitivity in clinical populations.

## Introduction

This review focuses on the effectiveness of early parenting interventions in enhancing maternal sensitivity in mothers with psychological difficulties (also described in this review as clinical problems or difficulties). Maternal sensitivity, sometimes termed maternal responsiveness, refers to the ability of a mother to perceive, understand and respond to her infant's signals and needs (Ainsworth, Blehar, Water & Wall, 1978). It is believed to be essential in the development of a secure attachment between a mother and her infant (De Wolff & Van IJzendoorn, 1997; Van IJzendoorn, Juffer & Duyvesteyn, 1995), with limited or inconsistent maternal sensitivity being linked to the development of insecure attachment, the consequences of which include social and emotional difficulties for the child in their pre-school years (Carlson & Sroufe, 1995; Cicchetti et al., 1998; Field, 1989; Radke-Yarrow, Cummings, Kuczynski, & Chapman, 1985; Spieker & Booth, 1988; Van IJzendoorn, Juffer & Duyvesteyn, 1995). When mothers experience psychological difficulties such as depression and other psychiatric disorders, numerous studies have indicated a negative impact on mother-infant interaction and security of attachment (Agras, Hammer & McNicholas, 1999), which then has implications for the social and emotional development and functioning of those infants.

Given the impact that psychological difficulties can have on maternal sensitivity and the key role of sensitivity in influencing children's longer-term socio-emotional adjustment (Van IJzendoorn, Juffer & Duyvesteyn, 1995), it is important to consider the effectiveness of parenting interventions which can enhance maternal sensitivity in clinical populations and thereby improve child outcomes. It has been argued that early parenting interventions are the most effective way to prevent deficits in children's development associated with parental psychiatric disturbance (Egeland, Weinfield, Bosquet, & Cheng, 2000; Huxley & Warner, 1993). Intervening early on is likely to minimise the negative impact a mother's clinical difficulties may have on her relationship with her infant.

In a meta-analysis of the effectiveness of early parenting interventions aimed at enhancing maternal sensitivity and attachment, Bakermans-Kranenburg, IJzendoorn and Juffer (2003) examined interventions for various populations such as adolescent mothers, premature infants and populations with multiple risks. One interesting finding was that early parenting interventions were more effective at enhancing maternal sensitivity in clinically referred populations (mothers clinically referred or fulfilling DSM-III-R criteria e.g. for major depression, or clinically referred children, e.g. for behavioural problems) than in any of the other populations ( $d = 0.46$  for clinically referred;  $d = 0.31$  for other populations). However, this result was based on the analysis of only eight randomised controlled studies involving both clinically referred mothers and clinically referred children and it was only a small part of an extensive meta-analysis, focusing on many different areas. There were no details in the meta-analysis about: the methodological quality of the studies analysed, the type of clinical difficulties or problems study populations presented with, the specific types of interventions used, how maternal sensitivity was assessed (the outcome measures used and whether component parts of maternal sensitivity measures were examined), and the timings of assessment (e.g. whether follow-up assessments were conducted).

Given the absence of a thorough examination of the evidence, including its methodological quality, it was not possible to determine the true meaningfulness of Bakermans-Kranenburg et al.'s (2003) finding that early parenting interventions were more effective at enhancing maternal sensitivity in clinically referred populations than in any of the other populations they examined. In addition, they did not provide information on which of the eight studies focused on clinically referred mothers, and which focused on clinically referred children.

## **Aims of the current review**

In light of this, the current review aimed to extend and update Bakermans-Kranenburg et al.'s (2003) review. Specifically it aimed to examine the evidence for early parenting interventions in enhancing maternal sensitivity in mothers with psychological difficulties, with a focus on the quality of the evidence. In summary, the review aimed to address the following questions:

- 1) How effective are early parenting interventions in enhancing maternal sensitivity in mothers with clinical problems?
- 2) Are there certain types of early parenting interventions that are more effective than others in enhancing maternal sensitivity in these mothers?
- 3) Are there certain clinical populations for which early parenting interventions are more effective in enhancing maternal sensitivity?
- 4) What is the methodological quality of these studies?

## **Method**

### **Inclusion Criteria**

The criteria for studies to be included in the review were as follows:

1. Study Population: Mothers with clinical difficulties or psychological problems, as determined by their scores on a symptom measure (e.g. scoring above a clinical cut-off on a measure of depression such as the Edinburgh Postnatal Depression Scale or Beck Depression Inventory) and/or meeting the DSM-III-R or DSM-IV diagnostic criteria for a particular psychiatric disorder.
2. Intervention: Studies of interventions focusing on mother-infant interaction or the mother-infant relationship and designed to increase maternal sensitivity.
3. Measures: Studies that measured and reported intervention effects on maternal sensitivity, and/or specific aspects of maternal sensitivity such as maternal approach behaviour, were included.

4. Study Design: Only controlled experimental designs were included. Both studies with randomised and non-randomised assignment of participants to treatment group and control group were included.

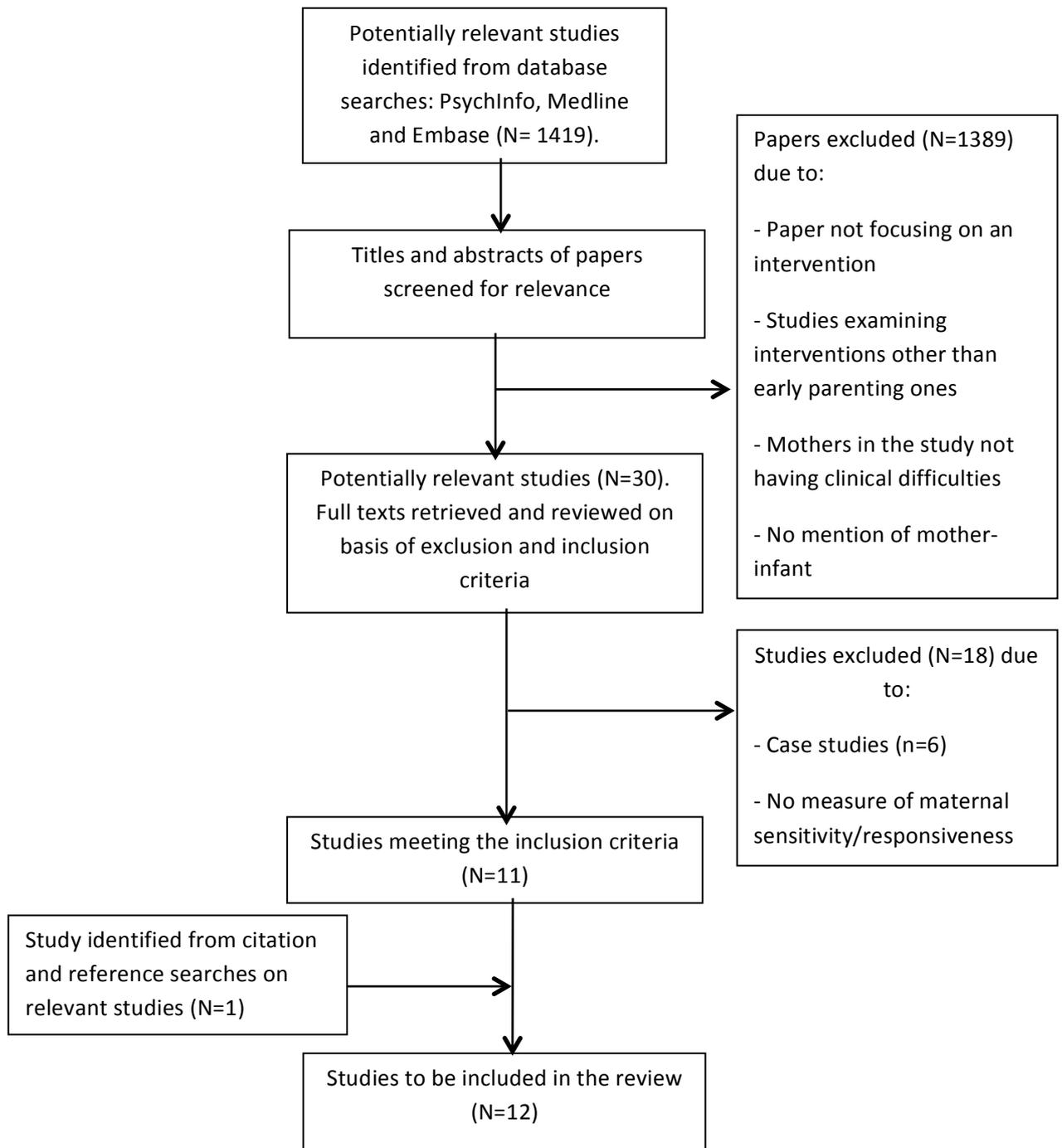
### **Search Strategy**

A search of the literature was conducted using the following search engines: PsychINFO, Medline and EMBASE. Database searches were restricted to English language papers and papers published up until November 2013. The searches were not limited to peer reviewed journals, as scoping searches showed that there were only a small number of studies and a few of the important studies were in the grey literature (published in a book). Each database was searched using four groups of terms; with each term in a group being linked by the 'OR' function to enable the identification of papers containing any of the terms in each group. The search for terms was limited to the title and abstract of papers.

The first group of search terms aimed to identify intervention outcomes (*attachment OR sensitivity OR responsiveness\* OR parent-infant OR mother-infant OR mother-baby OR interaction OR relationship*). The second group of terms aimed to identify intervention (and related) studies (*intervent\* OR prevent\* OR therap\* OR coach\* OR treat\**). The third group identified studies including young children (*infan\* OR child\* OR toddler\* OR baby OR babies*). The fourth and final group aimed to identify studies including parents (*parent\* OR mother\* OR maternal*). These four searches were then combined using the 'AND' function.

Figure 1 shows the process of selecting the studies for review. The database searches yielded 1419 studies. Scoping searches demonstrated that it was difficult to identify studies looking at interventions to enhance maternal sensitivity in mothers with clinical difficulties; therefore, to minimise the risk of missing any studies, search terms were kept broad. This meant that a large number of the 1419 studies were excluded when screened for relevance. The main reasons for exclusion at this stage were papers not being intervention studies, not considering early parenting

Figure 1: Selection of studies flowchart



interventions (if they were intervention studies), not studying mothers with clinical difficulties and/or not considering mother-infant relationship/interaction.

The full texts of potentially relevant papers (n=30) were then screened using the inclusion and exclusion criteria. The most common reasons for studies being excluded at this stage were: studies with a single case study design, and studies where no measure of maternal sensitivity or responsiveness (or aspects of either) was reported in the findings.

Of the 30 studies, 11 met the criteria for inclusion. Citation and reference searches were then conducted on these 11 studies, yielding one additional study. In total, 12 studies met the criteria for inclusion in this review.

### **Ratings of methodological quality**

The studies in the review were rated for methodological quality using a checklist developed by Downs and Black (1998), which is suitable for assessing the quality of non-randomised and randomised studies of interventions (See Appendix 1). It is a 27-item checklist, which enables the scoring of studies on four domains of criteria: reporting (e.g. 'Is the hypothesis/aim/objective of the study clearly described?'), external validity (e.g. 'Were the subjects asked to participate in the study representative of the entire population from which they were recruited?'), internal validity (bias) (e.g. 'Was an attempt made to blind those measuring the main outcomes of the intervention?') and internal validity (confounding- selection bias and power) (e.g. 'Was there adequate adjustment for confounding in the analyses from which the main findings were drawn?'). Downs and Black (1998) provide guidelines on using the checklist. Each item is scored with a one (study meets the criterion) or a zero (the study does not meet the criterion). The exception is item 5 ('Were the distributions of principal confounders in each group of subjects to be compared clearly described?') that can be given a score of two (study fully meets the criterion), one (study partially meets the criterion) or zero (study does not meet the criterion).

## **Data extraction**

A process of extracting data from each study was completed whilst rating study quality. Data was extracted for the following areas: study population, intervention, comparison (control) group, assessment time points, outcome measures and main findings. Consistent with the review questions, only the outcome measures and findings relevant to maternal sensitivity were extracted.

## **Results**

A summary of the 12 studies that met the inclusion criteria for the review is presented in Table 1. To ease comparison of study findings, the statistical significance of the difference between the control and treatment group in each study has been reported (p-value), alongside the measured outcome. In the case of no significant differences between groups, this has been reported in words (Horowitz et al., 2013).

The most common clinical difficulty of the mothers in the studies was depression (postnatal or other). Eleven studies examined the effectiveness of interventions for depressed mothers and the remaining one considered mothers with eating disorders. Most of the studies used interventions aimed at teaching, coaching or supporting the mother in identifying and interpreting her infant's cues and tailoring her responses to match the infant's needs. The interventions were administered through home visiting or in group settings.

With the exception of three studies conducted by Murray and Cooper (1997) and reported in a book chapter, all of the studies were published in peer-reviewed journals. The studies were conducted between 1992 and 2013. Seven of the studies were conducted in the United Kingdom, four in the USA and one in the Netherlands. Nine of the studies used a randomised controlled design and three used a non-randomised design (Clark et al. 2003; Fleming et al. 1992; Gelfand et al. 1996).

Table 1: Summary of Reviewed Studies

Study (Author and date)	Sample Size	Study population	Intervention	Comparison (control) group	Assessment time points	Outcome measures	Main Findings	Methodological quality (total score)
Clark et al. (2003)	39	Women who met the criteria for major depression in the post natal period	Mother-infant therapy. 12 weekly, 1.5hr sessions conducted by 2 therapists	Treatment as usual (TAU) and interpersonal psychotherapy comparison group	Pre and post	PCERA <sup>b</sup> ratings. Based on videotaped observations (5mins) of mother-infant during free play	Positive affective involvement and verbalization with infants (p=.005)	20
Fleming et al. (1992)	142	Postnatal depressed mothers with babies 6-8 wks old	Social support groups. 8 weekly, 2hr sessions conducted by 2 psychologists	No intervention group and Group-by-mail group	Pre (baby 6 wks old) and post(baby 5mths old)	Ratings based on observations (15mins) whilst mother feeding baby	Maternal approach behaviours (p<.03)	18

<b>Study (Author and date)</b>	<b>Sample Size</b>	<b>Study population</b>	<b>Intervention</b>	<b>Comparison (control) group</b>	<b>Assessment time points</b>	<b>Outcome measures</b>	<b>Main Findings</b>	<b>Methodological quality (total score)</b>
Gelfand et al. (1996)	111	Depressed mothers with infants 3-13mths old	Nurse Home Visit intervention. First 25 visits occurred at 1-3wk intervals during a 6mth–1yr period. The last 4 occurred less frequently	TAU (depressed) group and treatment group (non-depressed)	Pre and post	HOME <sup>b</sup> ratings based on home observations (Two 10-min sessions of feeding and free play)	Maternal responsiveness (p=.012)	23
Horowitz et al., (2001)	117	Postnatal depressed mothers and their 4-8 wk-old babies	ICAP <sup>a</sup> . At 4-8 wks postnatal, 10-14wks and 14-18 wks for approx. 15 minutes each time.	TAU	At each visit (T1: 4-8 wks postnatal, T2: 10-14wks and T3: 14-18 wks)	DMC <sup>b</sup> Scores. Based on live/videotaped observations (5mins) of face-to-face interaction during play.	Responsiveness (p=.006). Increase in responsiveness occurred between T1 and T2 (p=0.002) and maintained at T3 (p=0.29)	22

<b>Study (Author and date)</b>	<b>Sample Size</b>	<b>Study population</b>	<b>Intervention</b>	<b>Comparison (control) group</b>	<b>Assessment time points</b>	<b>Outcome measures</b>	<b>Main Findings</b>	<b>Methodological quality (total score)</b>
Horowitz et al., (2013)	125	Postnatal depressed mothers and their 6 wk old babies	CARE <sup>a</sup> . At 6 weeks and 2, 3, 6 and 9 months postnatal at home	TAU	At baseline (6 weeks) and 3, 6 & 9 months	NCATS <sup>b</sup> . Administered at home visits.	No significant differences between the treatment and control groups for maternal/infant relational effectiveness.	26
Murray and Cooper (1997)	90	Postnatal depressed mothers	Non-directive counselling. Weekly therapy from 8 until 18 wks postnatal.	TAU	Pre and postand 9 and 18 mths postnatal	Ratings (global rating scale developed by Murray et al. 1996) based on videotaped observations of mother-infant free play	No significant differences between treatment and control groups for maternal sensitivity	18

<b>Study (Author and date)</b>	<b>Sample Size</b>	<b>Study population</b>	<b>Intervention</b>	<b>Comparison (control) group</b>	<b>Assessment time points</b>	<b>Outcome measures</b>	<b>Main Findings</b>	<b>Methodological quality (total score)</b>
Murray and Cooper (1997)	89	Postnatal depressed mothers	Cognitive-behavioural therapy (CBT) in context of modified form of interaction guidance (McDonnough, 1993). Weekly therapy from 8 until 18 wks postnatal.	TAU	Pre and post and 9 and 18 mths postnatal	Ratings (global rating scale developed by Murray et al. 1996) based on videotaped observations of mother-infant free play	No significant differences between treatment and control groups for maternal sensitivity	18
Murray and Cooper (1997)	88	Postnatal depressed mothers	Dynamic psychotherapy (Stern, 1995). Weekly therapy from 8 until 18 wks postnatal.	TAU	Pre and post and 9 and 18 mths postnatal	Ratings (global rating scale developed by Murray et al. 1996) based on videotaped observations of mother-infant free play	No significant differences between treatment and control groups for maternal sensitivity	18

<b>Study (Author and date)</b>	<b>Sample Size</b>	<b>Study population</b>	<b>Intervention</b>	<b>Comparison (control) group</b>	<b>Assessment time points</b>	<b>Outcome measures</b>	<b>Main Findings</b>	<b>Methodological quality (total score)</b>
O'Higgins et al. (2008)	96	Postnatal depressed mothers and their 9-12 wk-old infants and non-depressed controls	Infant massage. 6 sessions of 1 hour infant massage class	TAU (non-depressed) and a comparison support group (depressed)	Baseline, after 6 sessions of intervention and at 1 yr (follow up).	Interactions between mother and infant (filmed for 5 minutes) whilst playing. Rated on Global Ratings for Mother-Infant interactions	No significant differences between treatment and control groups for maternal sensitivity	14
Onozawa et al. (2001)	22	Postnatal depressed mothers and their 9 wk-old babies	Infant massage. Weekly massage classes (1 hr class) for 5 wks. Also attended a support group for 5 wks.	Support group	On day of first massage class or support group and on day of last.	Engaged in face-to-face play interaction with their infants for a 5-min period. Rated using Global Ratings for Mother-Infant Interactions	Warmth (p=.01) Intrusiveness (p=.05)	23

Study (Author and date)	Sample Size	Study population	Intervention	Comparison (control) group	Assessment time points	Outcome measures	Main Findings	Methodological quality (total score)
Stein et al., (2006)	77	Women (meeting DSM-IV criteria for an eating disorder) with infants between 4 and 6 months old.	13 1-hour treatment sessions at home. Video-feedback interactional treatment, modification of that developed by Juffer et al.	Supportive counselling	Before treatment (infants 4-6mths old) and after treatment (infants 13mths).	Mother and infants videotaped during the principal solid meal of the day. Scored using time-sampled (measured every 2 mins then averaged) rating scales.	Maternal facilitation of infants (p=.02) Appropriate nonverbal responses to infant cues (p=.05) Number of responses to infant cues (Not significant)	25
van Doesum et al. (2008)	71	Dutch mothers who were depressed with an infant up to 12 months	Mother-baby intervention. Home visitors used video feedback used as a core intervention method. Interventions fine-tuned to mother's needs.	Parenting support by telephone	Pre, post1 (within 2 weeks of end) and post2 (6 months after post1).	Pre: Video-recording for 15-20 minutes while bathing baby. Post: video recording while playing for 15mins Video rated using EAS <sup>b</sup> .	Maternal sensitivity and structuring (p<.01).	23

<sup>a</sup> Interventions: CARE = Communicating and Relating Effectively; ICAP = Interaction coaching for at-risk parents and their infants

<sup>b</sup> Outcome Measures: DMC = The Dyadic Mutuality Code; EAS = Emotional Availability Scales; HOME = Home Observation for Measurement of the Environment; NCATS = The Nursing Child Assessment Teaching Scale; PCERA = Parent Child Early Relational Assessment

## **Synthesis**

The synthesis of studies focused on six main areas: the methodological quality of the studies, the type of interventions used, the characteristics of the sample, the study design, the outcome measures used, and the reported findings of the study, in relation to maternal sensitivity.

### **Quality of the studies**

The scores for each study on the four criteria of quality (Downs & Black 1998) are presented in Table 2. There were no major differences in the methodological quality of the randomised controlled design studies when compared to the non-randomised studies. The overall quality of studies was quite high, with a mean total score of 20.7 (out of 28).

The quality of reporting was quite high across most of the studies; however in the Murray and Cooper (1997) studies the quality of reporting was low. Some of the other studies also had weaknesses in their reporting but none were as pronounced as those in the Murray and Cooper (1997) studies. Common weaknesses were that studies did not describe, in sufficient detail, the principal confounders, such as age, education level and marital status of the mothers, for both the treatment and control groups. Additionally, in almost all of the studies, there was no description of any attempt to measure adverse events that could be the consequence of the intervention. In quite a few studies the characteristics of participants lost to follow-up were not described and in some of the studies, actual probability values (where appropriate) were not reported.

For most of the studies external validity was very high, with the exception of O'Higgins, St James Roberts and Glover (2008). From their paper, it was not possible to determine whether the study population invited to participate in the study, and those who agreed, were representative of the larger population, as details about the recruitment population were not provided.

Table 2: Methodological quality of studies

Study	Reporting (total =11)	External validity (total=3)	Internal validity- bias (total=7)	Internal validity – confoundin g (total =7)	Total score (total=28 )
Clark et al. (2003)	9	3	6	2	20
Fleming et al. (1992)	6	3	5	4	18
Gelfand et al. (1996)	10	3	6	4	23
Horowitz et al. (2001)	8	3	6	5	22
Horowitz et al. (2013)	10	3	7	6	26
Murray and Cooper (1997)	4	3	6	5	18
Murray and Cooper (1997)	4	3	6	5	18
Murray and Cooper (1997)	4	3	6	5	18
O’Higgins et al. (2008)	6	1	6	1	14
Onozawa et al. (2001)	9	3	6	5	23
Stein et al. (2006)	10	3	6	6	25
van Doesum et al. (2008)	9	3	6	5	23
<b>Mean Score (range)</b>	<b>7.4 (4-10)</b>	<b>2.8 (1-3)</b>	<b>6 (5-7)</b>	<b>4.4 (1-6)</b>	<b>20.7 (14-26)</b>

Internal validity (bias) and internal validity (confounding – selection bias) was fairly high across the studies, with the exception of the O'Higgins et al. (2008) study. They did not report whether the participants in the different intervention groups were recruited from same population and/or over same period of time, or whether there was adequate adjustment for confounding in their analyses. Some other common weaknesses in internal validity were due to studies not reporting whether losses of participants to follow-up had been taken into account. Additionally some of the studies are likely to have lacked power given their small sample sizes although this was discussed as a limitation in their papers. Only two studies reported conducting statistical power analyses (Horowitz et al., 2001; Horowitz et al., 2013); these were done prior to the recruitment of participants, with the sample size recommended by the power analysis then being recruited.

### **Type of intervention**

Three of the studies examined different types of established psychological therapies: one examined mother-infant psychotherapy, one CBT and one dynamic psychotherapy. Two studies examined infant massage, and two others examined interventions that involved video-feedback (one considered video-feedback interactional treatment, and the other examined a participant-tailored intervention with video-feedback at the core). The other five studies varied in their specific approaches: one considered non-directive counselling, one support groups, one a nurse home visit intervention, one an interactive coaching intervention, and one a relationship-focused behavioural coaching intervention.

Two of the interventions (non-directive counselling and dynamic psychotherapy) focused much more on the needs of the mother than those of the infant or the mother-infant relationship. This was in contrast to the other ten interventions that were much more clearly focused on the mother infant-relationship and the mothers' responses to their infants' needs.

Six of the ten interventions more focused on the dyadic relationship involved home visitors coaching mothers, partly through modelling and demonstration, in how to interpret their infant's cues and relate and respond more effectively to their infant. The video-feedback interventions (in the studies by Stein et al., 2006 and van Doesum et al., 2008) included discussion of videotaped interactions between them and their infants. The Horowitz et al. (2001; 2013) studies examined the Interaction Coaching for At-risk Parents and their infants (ICAP) and the Communication and Relating Effectively (CARE) interventions. Gelfand et al. (1996) considered a Nurse Home-Visit Intervention and Murray and Cooper (1997) examined a modified form of CBT in one of their studies.

Four studies examined interventions focusing on the dyadic relationship delivered in a group format. Two studies examined infant massage interventions (O'Higgins et al. 2008; Onozowa et al., 2001) that supported mothers to observe and respond to the cues of their infant, adjusting their touch accordingly. One study (Fleming et al., 1992) examined a support group that involved six to eight mothers (and their infants) discussing problems, conflicts and solutions. Two psychologists who led the sessions with topics such as 'motherhood' facilitated these support groups. One of the sessions also involved the mothers being instructed in infant massage. Another study examined a mother-infant psychotherapy group which involved dyadic activities (such as games which promoted nurturing and eye contact) designed to therapeutically support mothers to be more responsive and reciprocal in interactions with their infants.

All of the interventions described above were designed to increase maternal sensitivity; eight were administered through home visiting and the other four took place in a group setting. The length of the interventions studied ranged from five weeks to one year (mean length = 16 weeks); the number of sessions in each study ranged from three to 29 (mean number = 10); and the length of sessions ranged from 15 to 120 minutes (mean length = 66 minutes).

**Therapist characteristics.** All of the studies provided details of the therapists and/or home visitors administering the intervention. The therapists/home visitors were well-educated and experienced: three studies used therapists with a degree in education, child studies, psychology or social work, three used therapists trained in either CBT or non-directive counselling, three used home visiting nurses, two (the infant massage interventions) used trained members of the international association of infant massage and one used therapists experienced in child and family mental health care.

One of the studies reported specific training of therapists/home visitors and three reported supervision or feedback sessions being provided for therapists/home visitors throughout their administration of the intervention.

#### **Characteristics of participants**

The sample size of the studies ranged from 22 to 142 (mean sample size = 89). All studies focused on mother and child pairs. Nine of the studies reported the mean age of mothers in the studies, which ranged from 29 to 32 with the youngest mother reported to be 17 and the oldest 45. In four studies all of the mothers were first time mothers; in four approximately half of the mothers were first time mothers; four studies did not report whether the mothers were first time mothers or not. In five studies almost all, or all, of the mothers were married or living with a partner; in one study only half of the mothers were married or living with a partner; and in six studies no information about marital status or living arrangements of the mothers was provided.

The age of children, at the start of intervention, ranged from 5 to 36 weeks old (mean age = 12 weeks old). Seven studies did not report the ratio of boys to girls in their sample; in five studies there was an almost equal ratio of boys to girls.

Nine of the studies did not report exclusion criteria. The most common reason for exclusion in the other studies was (sometimes comorbid) diagnosis of a severe psychiatric disorder in the mother, such as psychosis or schizophrenia. One

study excluded mothers with previous gynaecological complications; one study excluded both children and adults with severe medical conditions; and one study excluded participants if the infant had gross congenital abnormality or had been admitted to a special care baby unit.

With the exception of one study that considered mothers with eating disorders, all of the studies examined mothers who were depressed. Of these studies, only two studies reported on whether the depressed mothers had experienced depression prior to the birth of their child. In one of these studies around half of the mothers with post-natal depression had experienced an earlier episode of depression; in the other study most of the mothers with post-natal depression (85%) reported at least one previous episode of depression.

### **Study design**

Nine of the 12 studies used a randomised controlled trial (RCT) design, although there were variations in the methods of randomisation. Six studies used simple random allocation; one used a block controlled randomised design; one study used the sealed envelope technique to randomise assignment to the intervention or control group and another used a computer generated list. Three of the 12 studies used a non-randomised controlled design: one assigned a mix of depressed and non-depressed mothers to the control or intervention groups in blocks of eight (in line with the intervention, a support group, requiring eight mothers), one study used a group-based matching procedure to assign participants (all depressed mothers) to the intervention and control groups and also recruited a non-depressed control group and the third study sequentially assigned mothers to an intervention or control group and additionally recruited mothers to a comparison intervention group.

Five of the 12 studies compared one treatment group to one control group receiving treatment as usual. Four of the 12 studies compared one treatment group to two control groups: one study compared the treatment group with one group

receiving treatment as usual and a comparison group receiving alternative therapy; one compared the treatment group to one group receiving no intervention and a comparison group receiving alternative support; one compared the treatment group to one depressed group receiving treatment as usual and a non-depressed group receiving the treatment being studied; and one study compared the treatment group to one non-depressed group receiving treatment as usual and a depressed comparison group receiving the treatment being studied.

The remaining three studies compared a treatment group with one control group which received a form of parenting support: one used a support group control, one a supportive counselling control and one parenting support by telephone.

All of the studies compared maternal sensitivity pre- and post-intervention, and two studies additionally measured maternal sensitivity at time points during the intervention. One of these studies did this halfway through the intervention and the other two months after the intervention had started and then again two months before the intervention finished. Five of the studies included one or more follow-up assessments; time of follow-ups ranged from 6 to 13 months. The number of participants who completed the intervention and whether there was attrition was not clearly reported in three of the studies. In the studies that did report attrition, rates ranged from 4 – 33% (mean attrition rate = 11.5%).

### **Outcome measures**

In all of the studies, the outcome measures involved behavioural observation of mother and child pairs whilst they were interacting and a subsequent coding or scoring of this interaction. This was either done 'live', whilst interaction was happening, or whilst viewing a videotape of the interaction. The length of time for which mother-infant pairs were observed at each assessment time point ranged across nine of the studies from 5–20 minutes (mean time = 10 minutes). Information about length of each observation was not available for three of the studies.

With the exception of one study, for which there was no information about activity during observation, mother-infant pairs in the studies were observed during bathing, feeding or play. In seven studies, mother-infant pairs were observed whilst playing; in one study mother-infant pairs were observed during play and also during feeding; in one they were observed during feeding; in one study, which involved mothers with eating disorders, the mother-infant pairs were observed during mealtime; and in one the pair were observed during bathing at pre-test and then during play at post-test.

The observations in nine of the 12 studies were coded or scored by trained, blinded coders. Of the other three studies; in one a random selection of 10 (total sample size of 22) of the observations was coded by trained, blinded coders, and in the other two studies not enough information was given to determine if coders were trained and/or blinded. Five of the 12 studies reported on the inter-rater reliability of the coders; and all of these reported sufficient inter-rater reliability, ranging from 0.85 to 0.92.

In three studies, a nominal scale was used when coding observations; items on the Nursing Child Assessment Teaching Scale (NCATS), Dyadic Mutuality Code (DMC) and behaviours such as affectionate contact (not using a specific scale) were scored as either present or absent. Both the NCATS and the DMC are valid and well-established measures of responsiveness in the mother-infant relationship and mother-infant relational effectiveness (Censullo, 1991; Censullo, Bowler, Lester & Brazelton, 1987; Huber, 1991; Sumner & Spietz, 1994). The third study did not report using a validated or established measure and instead just reported the categories under which behaviours were observed. They reported these to include: affectionate contact, instrumental activities and other-directed behaviours.

In the other nine studies, interval scales were used to code observations of mother-infant pairs. Five studies used the Global Ratings for Mother-Infant Interactions (Murray, Fiori-Cowley, Hooper & Cooper, 1996). This well-established

rating system is similar to other reliable and valid rating systems for assessing the engagement between a mother and her infant (Cohn, Matais, Tronick, Connell & Lyons-Ruth, 1986; Field, Healy, Goldstein & Guthertx, 1990). Of the remaining four studies, three used well-established and valid measures: one used the Emotional Availability Scales (EAS; Biringen, Robinson & Emde, 2000) which includes a measure of parental sensitivity, one used the Parent Child Early Relational Assessment (PCERA; Clark, 1983, 1999; Clark, Hyde, Essex & Klein, 1997; Clark, Keller, Fedderly and Paulson, 1993; Mothander, 1990; Teti, Nakawaga, Das & Wirth, 1991) which assesses the quality of the mother-infant relationship and one used the Home Observation for Measurement of the Environment (HOME; Caldwell, Heider, & Kaplan, 1966) to assess maternal responsiveness. The final study reported development of their outcome measures using two sources describing well-established measures (Ainsworth, Bell & Stayton, 1974; Stein, Woolley, Cooper & Fairburn, 1994); however, the actual reliability or validity of the scales they developed is not clear.

In summary, all 12 studies used the same method of gathering data about the mothers, i.e. short behavioural observations, and these observations were completed in the context of everyday situations (playing, bathing and feeding). In most of the studies the observations were coded/scored by trained, blinded coders using valid and well-established measures. However, over half of the studies did not report whether the inter-rater reliability of the coders had been measured and/or was sufficient.

### **Study findings**

The 12 studies varied in how they reported their findings related to maternal sensitivity, either splitting the construct into component parts or reporting on it as a whole. The components of maternal sensitivity reported on included positive affective involvement and verbalization with infants, maternal approach behaviours,

maternal warmth and intrusiveness, appropriate control of infants, facilitation of infants and responses (verbal and nonverbal) to infant cues.

Seven of the studies reported their findings in terms of a single index for maternal sensitivity (or responsiveness, given the inter-changeability of these terms). Five of the 12 studies only reported findings for specific aspects of maternal sensitivity: one reported findings for maternal positive affective involvement and verbalization with infants, one presented findings for maternal approach behaviours, one for maternal/infant relational effectiveness, one for warmth and intrusiveness of mothers and one presented findings for maternal facilitation of infants, appropriate nonverbal responses to infant cues and number of responses to infant cues.

Seven of the studies (six of depressed mothers, one of mothers with an eating disorder) reported statistically significant increases in maternal sensitivity and/or components of it following the intervention. All of these studies examined interventions focused on the dyadic relationship and aimed at teaching, coaching or supporting the mother in identifying and interpreting her infant's cues and tailoring her responses to match the infant's needs. Home visitors administered four of these seven interventions and the other three took place in group settings. Two of the home visiting interventions involved video-feedback, where the mother was supported in becoming aware of, and more responsive to, her infant's needs through discussion of videotaped interactions between her and her infant. The other two were similar, in that they involved home visitors coaching mothers in how to interpret their infant's cues and relate more effectively to them; however, videotape of mother-infant interaction was not used.

Of the three group interventions, two involved mother-infant activities (infant massage and a mother-infant psychotherapy group) that were designed to promote the mother's observation of, and responsiveness to, her infant's cues. The other group intervention was slightly different in that it was a support group where mothers talked about different topics affecting their relationship with their infant, such as their

experiences of motherhood; however one of the eight group sessions did focus on infant massage.

The methodological quality of the seven studies which reported statistically significant increases in maternal sensitivity was quite high, ranging from 18 to 25 (mean quality = 22); however, the average quality of the three studies which were non-randomised was slightly lower than that of the four studies which were randomised (mean for non-randomised = 20; mean for randomised = 23). Of the seven studies, five compared the treatment group to a control group receiving a form of parenting support. One of the studies (examining depressed mothers) used a treatment group of non-depressed mothers as one of their control groups; their other control group was treatment as usual for depressed mothers. The seventh study compared their treatment group to a treatment as usual control group.

Only one of the seven studies included a follow-up period. This study reported the maintenance of a statistically significant increase in maternal sensitivity and structuring six months after the conclusion of the intervention. All seven studies used different outcome measures, with five of the seven reporting the use of valid and well-established measures and three of these studies also reporting sufficient inter-rater reliability (0.85, 0.90 and 0.92).

### **Discussion**

This review included 12 studies, seven of which reported statistically significant increases in the maternal sensitivity (or aspects of it) of mothers with psychological difficulties following an early parenting intervention. This provides some evidence that early parenting interventions can be effective in increasing maternal sensitivity in clinical populations compared to no treatment, treatment as usual or some form of parenting support. However, nearly all the evidence is based on mothers who have depression rather than any other clinical difficulty.

In terms of the most effective type of intervention, a broad range of interventions was included in the review and so it is not possible to draw conclusions

about any specific type of intervention. However, the interventions were all administered through either home visiting or in group settings. In relation to the home visiting interventions, the review provides mixed evidence for their effectiveness. Eight studies involving this method of intervening were included in the review and only four of them reported statistically significant increases in maternal sensitivity.

Four studies in the review examined group-based interventions and three of these reported statistically significant increases in maternal sensitivity and, of note, the fourth study had the lowest methodological quality of all the studies reviewed. This provides some evidence that group-based early parenting interventions are effective in improving maternal sensitivity. The group-based interventions were similar to home visiting interventions in that they aimed to support mothers to identify and respond to their infant's needs. In two of the group interventions this was done specifically through mother-infant activities and in one this was done through mothers gaining support from each other during structured discussion.

In addition to the evidence for group-based interventions, two of the interventions reviewed involved video-feedback and both of these were effective in improving maternal sensitivity, providing some limited evidence for the effectiveness of this specific method.

The outcome measures used in the studies were quite varied; however five of the studies did use the same measure, the Global Ratings for Mother-Infant Interactions (Murray et al., 1996). All of the measures used involved short behavioural observation of the dyad whilst they interacted in an everyday context (e.g. playing) and most of them were valid and well-established measures. Of the seven studies which reported statistically significant increases in maternal sensitivity, each one used a different outcome measure and these included the only two measures (out of the 12 studies) where the validity, or how well-established they were, was not clear. The variation in the outcome measures used means it is not

possible to provide evidence for the effectiveness of specific outcome measures in measuring changes in maternal sensitivity.

None of the studies reviewed reported indices of the magnitude of change (i.e. effect sizes) or of the clinical significance of increases in maternal sensitivity. By only providing information on statistically significant change, the meaningfulness of the findings (in terms of how much of an effect the interventions have on maternal sensitivity and whether this is important in terms of current clinical theory or practice) cannot be determined.

Furthermore, most of the studies reviewed did not have follow-up periods, rather concentrating on immediate post-intervention findings. This greatly limits any conclusions that can be drawn about the long-term effectiveness of early parenting interventions on maternal sensitivity in clinical populations.

### **Study quality and methodological considerations**

The quality of the studies in this review was quite high overall, lending support to the findings. Of the seven highest-quality studies (studies with a total score on the Downs & Black, 1998 checklist of over 18), six of them were included in the seven studies that reported statistically significant results. Within the seven studies with statistically significant results, the non-randomised studies were slightly lower quality than the randomised ones. This is consistent with the generally more robust methodological nature of the randomised controlled trial design.

With the exception of the studies by Murray and Cooper (1997), the quality of reporting was quite high, and external validity was very high in all but one of the studies. In most studies the mothers asked to participate, and those who did participate in the study, were representative of the population from which they were recruited, and the interveners and places of intervention were typical of early parenting interventions. This demonstrates that the findings of the studies can likely be generalised to the population from which the study participants were derived (e.g. post-natal depressed mothers).

Internal validity (bias and confounding) of studies was also generally high; assessors were blinded, the outcome measures used tended to be reliable and the statistical tests used to measure the outcomes appropriate. However, reporting of principal confounders in the design was not detailed enough in many of the studies and future studies would benefit from clearer reporting of these confounders. In most of the studies, adequate adjustment for confounding in the analyses was conducted.

Some of the studies may have lacked statistical power due to their small sample sizes and the specificity of the outcomes measured. Only two of the studies reported conducting power analyses prior to recruitment, and it is recommended that future studies conduct and report power analyses. It is important for studies to have sufficient power to detect an effect that exists.

Most of the studies reported attrition rates; however, many of them did not describe the characteristics of participants lost to follow-up or report taking into account the losses of participants to follow-up. It is important that this is clearly reported in the future to enable selection bias in studies to be adequately assessed.

This review used a checklist developed by Downs and Black (1998), which is suitable for assessing studies using non-randomised as well as randomised designs. This checklist enabled systematic assessment of study quality. The checklist covers a range of areas concerned with study quality; however, there were some important methodological considerations that were not included. One of these areas was follow-up of participants once they had completed the intervention, the implications of which have been discussed earlier in this discussion.

Another area that was not included in the Downs and Blacks (1998) checklist is the type of control group used for comparison with the treatment group. Approximately half of the studies reviewed used control groups receiving treatment as usual and one used a control group receiving no intervention, the other half using control groups which received alternative interventions. The alternative interventions

involved nonspecific forms of parenting support (e.g. interpersonal therapy, telephone support, support group and supportive counselling) that did not directly address maternal sensitivity. The type of control condition used in randomised and non-randomised control trials can impact on the study's internal validity. A study where the control condition involves a nonspecific treatment is likely to have greater internal validity than a study where the control condition involves treatment as usual or no treatment (Mohr et al., 2009). It would be useful for future research to aim for nonspecific treatment control conditions to decrease the threat to internal validity, and therefore improve the quality of the studies.

### **Limitations of the review**

Limitations of this review are the relatively small number of studies included, issues with the methodological quality of some of the studies, and the heterogeneity of the outcome measures. This made it more difficult to provide comprehensive evidence for (or against) the effectiveness of early parenting interventions on maternal sensitivity in clinical populations. The small number of studies reviewed is partly due to quite limited research being published in this specific area.

In terms of the heterogeneity of the outcome measures and the relatively low methodological quality of some of the studies, the aim of this review was to examine as many studies with measures relevant to maternal sensitivity as possible. However, it would be useful for further reviews to consider studies with different outcome measures separately and to consider methodological quality more closely in terms of which studies are included in a review.

### **Clinical implications and future research**

It is important that future studies report more clearly on their methodology, enabling the impact of issues such as attrition and statistical power to be assessed. It would also be useful for future studies to consider the type of control condition used and the long-term impact of the intervention on study participants. Our understanding of the impact of early parenting interventions on maternal sensitivity

in clinical populations could also be furthered through qualitative analysis of how the mothers involved in the interventions experience them.

This review suggests that early parenting interventions have the potential to improve maternal sensitivity in mothers who have clinical difficulties. However this review is limited to mainly considering mothers with depression, with only one study presenting statistically significant findings when intervening with mothers who have an eating disorder. It remains to be seen whether these interventions are effective across a wider range of clinical difficulties and also whether there are particular clinical populations, such as depressed mothers, for whom the interventions are more effective. Additionally, it is important to further examine which types of early parenting intervention, e.g. home visiting vs. group-based interventions, are most effective, bearing in mind that different clinical populations may respond in different ways to interventions.

## **Conclusions**

This review revealed mixed evidence for the effectiveness of early parenting interventions in enhancing maternal sensitivity in certain clinical populations, particularly mothers with depression. Given the small number of studies reviewed, further research is needed to examine the efficacy and effectiveness of these interventions. A wider range of clinical populations needs to be considered to enable identification of any differences in the effectiveness of these interventions in enhancing maternal sensitivity within those populations. Additionally, further examination of different types of early parenting intervention and outcome measures will be important in identifying the best way to intervene with clinical populations and to measure maternal sensitivity in clinical populations.

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**Part 2: Empirical Paper**

**Mothers' experience of therapeutic processes in a reflective parenting programme**

## **Abstract**

**Aims:** Minding the Baby (MTB) is a parenting programme designed to improve the reflective functioning of mothers from disadvantaged backgrounds. There is initial evidence that MTB is successful in improving reflective functioning; however, little is known about the underlying processes of mothers' engagement and subsequent change. This qualitative study aimed to address this through exploring mothers' experiences of engagement and change in MTB.

**Method:** Semi-structured interviews were conducted with 16 mothers and three fathers currently involved in MTB. Thematic analysis (Braun & Clarke, 2006) was used to analyse the transcripts.

**Results:** Parents reported changes in both their parenting skills and themselves (e.g. increased confidence and wellbeing) and they described characteristics of both the MTB programme and MTB practitioners that had facilitated their engagement and the subsequent changes. They valued the individualised, flexible and collaborative nature of the programme, as well as the close, trusting relationships that they felt had developed between them and their practitioners.

**Conclusions:** These findings illustrate the importance of strong therapeutic relationships, as well as the tailoring of parenting programmes to parents' needs, in order to facilitate the engagement and subsequent change of disadvantaged parents. More research is required to understand the experiences of parents who have difficulties engaging in parenting programmes. In addition, further research is needed to consider the impact of the therapeutic relationship, in particular the development of mutual trust, on the success of parenting programmes.

## **Introduction**

Influential models of child development suggest that factors operating at multiple levels of the family ecology influence the child's developing social, emotional and cognitive competencies (Bronfenbrenner, 1989). A key common pathway through which these contextual factors influence child development is the quality of parenting (Belsky, 1984). Adverse social circumstances, such as poverty, homelessness, poor education and low social support, appear to undermine parenting and attachment security, which consequently impact upon the child's broader social and emotional development (Hamburg, 1992; Lerner, 1995; Masten, 1992; Sandefur, McLanahan, & Wojtkiewicz, 1992). Extensive research shows that adverse social circumstances are associated with poorer mental and physical health outcomes for children, lower academic achievement, more difficulties in relationships with others and greater social isolation (Shonkoff & Phillips, 2000).

### **Social adversity and parenting**

A wide range of adverse circumstances have been found to impact upon a parent's ability to meet the needs of their child or to respond to their cues with appropriate sensitivity. These adversities include: 1) having had a teenage pregnancy, 2) experience of maltreatment in childhood, 3) experience of foster care, 4) being a single parent, 5) being homeless, 6) experiencing poverty, 7) having mental health problems, 8) abusing substances and 9) being exposed to, or involved in, violence (Hamburg, 1992; Lerner, 1995; Masten, 1992; Sandefur, McLanahan, & Wojtkiewicz, 1992; Slade, 2006). For example, research has found that parents under the age of 19 years old have limited sensitivity and are less responsive to their children's needs (Jones, Green & Krauss, 1980). In addition, mothers who are depressed have been found to be limited in their ability to provide safe and secure environments for their children, displaying more hostile and rejecting behaviour towards them (Colletta, in press; Orraschel, Weissman & Kid, 1980).

One important area impacting upon child development and associated with parents' experience of social adversity is the quality of attachment between parent and child (Carlson & Sroufe, 1995; Cicchetti et al., 1998; Field, 1989). Research suggests that disorganised attachment is more prevalent in individuals experiencing multiple adversities (Carlson, 1998). For example, disorganised attachment is found at higher rates among the children of parents with substance abuse problems, unresolved trauma or children who are being maltreated by their parents; all of these parenting problems occur at much higher rates in impoverished communities (Madigan et al., 2006; Main & Hesse, 1990; van IJzendoorn, Schuengel & Bakermans-Kranenburg, 1999). Insecure and particularly disorganised attachments are associated with poorer social competence and higher rates of emotional and behavioural problems (Sroufe, 2005). Thus, the quality of parenting and the security of the mother-infant attachment relationship are an important set of early developmental processes through which social adversity may impact on child development.

### **Attachment and reflective functioning**

There is considerable evidence that the early security of a child's attachment is associated with a parent's reflective functioning capacity (Fonagy et al., 1995; Slade, Grienenberger, Bernbach, Levy & Locker, 2005). Reflective functioning refers to the ability to understand the mental states of oneself and others and how these influence the behaviour of oneself and others (Fonagy, Gergely, Jurist & Target, 2002). Parents high in reflective functioning, as measured by the Adult Attachment Interview, are more likely to have secure attachment styles themselves and to have children who are securely attached by the age of one year. Conversely, parents with low reflective functioning are more likely to have insecure attachment styles and their children are likely to be insecurely attached (Fonagy, Steel & Steele, 1991; Fonagy et al., 1995). Consistent with this, deficits in parental reflective functioning have been linked to disorganised attachment in infants and difficulties in the

expression of emotions in the relationship between the parent and infant (Grienenberger, Kelly & Slade, 2005).

Several studies have indicated that parental reflective function influences the sensitivity of parenting, which in turn may account for the association between parental reflective functioning and infant attachment (Fonagy et al., 2002; Fonagy & Target, 1997; Rosenblum, McDonough, Sameroff & Muzik, 2008; Slade, 2005; van IJzendoorn, 1995). Parents from disadvantaged backgrounds are more likely to have limited reflective functioning, due to deficits in their own attachment experiences and development (Fonagy et al., 2002; Slade, 2006; Slade, 2005). It has therefore been argued that parenting programmes focusing on improving the reflective functioning of these parents may improve the quality of attachment and facilitate the social and emotional development of their children (Sadler et al., 2013; Slade, 2006).

### **Home visiting parenting programmes**

In light of the multiple and complex needs of families in poverty (Shonkoff & Phillips, 2000), interventions designed to support such families have often used a home visiting model, in order to improve engagement and manage the multiple stressors impacting on the family. Engagement can be a particular challenge when working with highly impoverished communities (Lundahl, Rissu & Lovejoy, 2006; Reyno & McGarth, 2006). This can be due to social adversity factors such as: poverty, poor mental and physical health, negative perceptions of how effective and helpful services are (Garvey et al., 2006; Gross et al., 2001), and limited emotional and social functioning (Sainsbury Centre, 1998). Considerable evidence supports the notion that delivering supportive interventions in the home, on a regular basis and with a trusted and consistent practitioner, can be an effective way to engage and facilitate change in these complex families (Heinicke, Fineman, Ruth, Recchia, Guthrie & Rodning, 1999; Heinicke et al., 2000; Kitzman et al., 2010; Lieberman,

Silverman & Pawl, 1999; Lieberman, Weston & Pawl, 1991; Olds et al., 2010; Olds, Sadler & Kitzman, 2007).

The Nurse Family Partnership (NFP; Olds et al., 2007) is a well-established home visiting programme that has shown good evidence of engagement and of improved outcomes (Kitzman et al., 2010; Olds et al., 2010; Olds et al., 2007). Infant-Parent Psychotherapy (IPP; Lieberman, Silverman, & Pawl, 1999) is another home visiting programme and it is associated with improved attachment security (Heinicke et al., 1999; Heinicke et al., 2000; Lieberman et al., 1999; Lieberman, et al., 1991). NFP is delivered through regular home visits carried out by nurses until the child is two years old; IPP is delivered by social workers or psychologists also through regular home visits but treatment length varies. Both interventions aim to promote the dyadic relationship and the parents' sensitivity to their children's needs through the relationship between the clinicians and parents. One clear limitation of NFP is that it provides mothers with physical health information and support but does not consistently address attachment, parenting or the mental health needs of young parents experiencing adversity (Howard & Brooks-Gunn, 2009). IPP focuses on maternal mental health and aims to facilitate improvements in both parenting and attachment; however it does not place any focus on the physical health or lifestyle of parents.

### **Minding the Baby**

Until recently, home visiting programmes for parents from complex backgrounds have not explicitly concentrated on the development of reflective capacity, and as noted already, have tended to focus on physical health or attachment, but not both. However, Slade and colleagues (Goyette-Ewing et al., 2003; Slade, 2002; Slade, 2006) have recently developed a home visiting programme designed to promote parental reflective functioning and secure attachment, whilst also addressing the family's physical and mental health needs. Minding the Baby (MTB) was developed to combine the strengths of both NFP and

IPP in order to create an intervention that could most adequately meet the complex needs of young mothers experiencing multiple adversities (Sadler et al., 2013). The programme was influenced substantially by NFP (Olds et al., 2007) and IPP (Lieberman et al., 1999). It was also strongly influenced by the literature on mentalization-based interventions with families (Grienenberger, Denham & Reynolds, in press; Pajulo, Suchman, Kalland & Mayes, 2006; Suchman, DeCoste, Castiglioni, McMahon, Roun- saville & Mayes, 2010).

MTB is targeted at mothers under 25 years old who are from disadvantaged backgrounds and are experiencing social adversity. The programme starts when the mother is in her third trimester and ends when their child is two years old. A pair of practitioners (one nurse practitioner and one clinical social worker) visit the mother regularly, once weekly in the first year and then once a fortnight (gradually becoming more infrequent) in the second year. At its heart, MTB involves supporting a progressively more complex ability of the parent to maintain a consideration of their child's needs in any given context or situation. Slade (2006) proposes that parents experiencing highly adverse circumstances, many of whom will have experienced trauma and neglect during their own upbringing, have first to be progressively supported in understanding and tolerating their child's needs before being supported to develop more sophisticated reflective functioning. This understanding and tolerance of a child's needs can include even the most basic ones, such as a child's need to be cared for or attended to in some way (e.g. feeding, changing and/or comforting) when distressed. In the MTB model (Slade, 2006) the practitioners play a key role in modelling reflectiveness, by focusing on both the parent's and the child's internal experiences and needs, which is believed to be crucial to the development of a reflective stance in parents. 'Facilitating wonder', for example, is a key element of the model, in which the practitioners facilitate, through modelling, the parent's curiosity about their child's needs and internal experiences (e.g. if the child is turning the television on and off, or playing with the remote control, the practitioner

might wonder aloud with the parent about the child's eagerness to explore their world). This modelling aims to help parents to understand their child's subjective states and motivations and that the needs and internal experiences of their child are separate from their own. Practitioners also make use of times when parents' emotions are aroused to help them understand their own emotional regulation, as well as that of others (Fraiberg, 1980). An individual's experience of parenting can provide access to their own experiences of being parented, which for parents experiencing multiple adversities may produce difficult emotions and memories that are poorly processed or integrated (Fraiberg, 1980). Focusing on the needs and internal experiences of their child can enable parents to consider the complex interactions between the past and the present.

The first wave of outcomes in a pilot-phase randomised control trial of the MTB programme (Slade et al., 2013) showed that the reflective functioning of the mothers who had the lowest educational level and very low reflective functioning at the start of programme, improved, in comparison to controls. The RCT also found that MTB had a positive impact on health and parenting outcomes; at four months into the programme, interactions between mothers and infants had improved and, at 12 months, the rate of secure attachment had risen alongside a fall in the rate of disorganised attachment. There was also a move towards less involvement with child protection services at 24 months and mothers were more attentive to their children's health needs.

The outcomes in this RCT were measured quantitatively. The main outcome, reflective functioning, was measured using structured, clinical interviews (the Pregnancy Interview; Slade, 2003 and the Parent Development Interview; Slade et al., 2004), the transcripts of which were then scored and coded using a well-established coding system (Slade et al., 2013). One limitation of these quantitative measures is that they provide little information on the processes underlying changes

in reflective functioning (or the other changes) or on the process underlying the mothers' engagement in the MTB programme, which precedes any change.

Qualitative research enables a more detailed exploration of individuals' experiences than that usually available through quantitative research. Specifically, in-depth interviews allow the exploration of experiences that may be too complex to be examined through quantitative methods (Barker & Pistrang, 2010). A mixed-method approach, particularly the inclusion of qualitative methods within an RCT evaluation of an intervention, has been recommended as a strategy for better understanding therapeutic processes and outcomes (Lewin, Glenton & Oxman, 2009; Midgley, Ansaldo & Target, 2014).

### **Qualitative research on parenting programmes**

Previous qualitative research has considered the experiences of parents involved in parenting programmes, both in relation to their engagement and change. For example, Kurtz Landy et al. (2012) explored the experiences of parents involved in the NFP program. The themes they identified suggest that the parents were engaged in, and had a positive experience of, NFP through the strong therapeutic relationships they developed with their home visiting nurses. In a review of parenting interventions, Kane, Wood and Barlow (2007) suggested that parents felt the knowledge, skills and understanding they had gained from interventions led them to feel less guilty, be more empathic and to feel more confident in managing their children's behaviour.

### **Rationale and aims of current study**

Given the findings from previous qualitative research on parenting programmes, greater understanding of the processes underlying the engagement and change of mothers involved in MTB is likely to be gained through a qualitative study of their experiences. Understanding this engagement and change is important to the development and future success of the MTB programme, as well as that of other interventions with parents experiencing multiple adversities.

The current study addressed the following research questions, from the perspectives of the mothers involved in the MTB programme:

1. What do mothers perceive facilitates or hinders their engagement with the programme?
2. What, if anything, do the mothers perceive to have changed as a result of the programme and what has facilitated or hindered that change?

### **Method**

This study was part of a larger UK pilot study of the Minding the Baby (MTB) parenting programme. It was conducted in collaboration with another UCL Clinical Psychology Doctorate student (Grayton, 2014). Appendix 2 provides further information on each of the two researchers' contributions to the project.

### **Intervention**

Minding the Baby (MTB) is a preventive parenting programme that focuses on improving the reflective functioning of young mothers experiencing multiple adversities (Slade et al., 2010). This target population is defined as mothers being under 25 years old, and having additional needs including: homelessness; refugee or asylum seeker; learning difficulties; relationship conflict; significant pathology, alcohol abuse in family; poverty; history of maltreatment or neglect in own childhood; and experience of being looked after by the local authority. Exclusion criteria include mothers with serious mental illnesses; actively engaged in problematic drug abuse; with severe or profound learning difficulties; with severe and life-threatening physical illness; and who do not speak English.

An interdisciplinary team, consisting of paediatric nurse practitioners (NP) and clinical social workers (CSW), implement the programme. A pair of practitioners (one NP and one CSW) start visiting the mother at home in her third trimester of pregnancy and provide regular home visits and other support (e.g. via telephone) from then, until the baby is two years old. The practitioners support the mothers' reflective parenting, promote the attachment relationship between the mother and

infant, and promote development of parenting skills (Sadler et al., 2013). The practitioners use various methods for supporting the development of reflective capacity, such as modelling a reflective stance during visits (e.g. curiosity about the child's and parent's state of mind) and facilitating activities (e.g. play and making scrapbooks) during which practitioners can narrate some of the feelings being experienced by both mother and infant (Sadler et al., 2013). They also have other roles (both distinct and overlapping) including providing: health education, advice on child development, various therapeutic approaches dependent on their assessment of the mother's and child's needs, and help with any legal or court issues (Sadler et al., 2013).

MTB was developed in an inner-city community in the USA. The present study considered mothers involved in a National Society for the Prevention of Cruelty to Children (NSPCC) pilot of MTB that was taking place in three urban sites in the UK. Mothers were recruited into the program on the basis of the inclusion and exclusion criteria described above. In contrast to the USA implementation of the programme, which focused solely on mothers, some fathers (of babies involved in the programme) also participated in the programme alongside their partner. The duration of the programme was as stated above, as were the roles of the practitioners. The practitioners alternated their weekly home visits and then reduced to alternating fortnightly visits after babies turned one year old.

### **Ethical Approval**

Ethical approval was obtained from the UCL Ethics Committee (See Appendix 3).

### **Participants**

**Recruitment.** Parents were recruited for this study from the three MTB UK pilot sites by asking the MTB practitioners to talk to the mothers who they were working with about being involved in the research. The researcher firstly developed relationships with the practitioners at each site through email and telephone contact

with them. They were provided with some background information about the nature of the research and were sent the study information sheet.

In order to shed light onto the perhaps more subtle, detailed and specific aspects of engagement and change, we wanted to recruit mothers who had been in the programme for over one year (baby approximately 9 months or older). Practitioners were asked to talk to those mothers about the research, to provide them with the information sheet, and to ask if they were happy to be contacted (by telephone) by the researcher to discuss taking part in the study.

Initially, a purposive sampling strategy was going to be used to recruit mothers who had engaged well, and those who had difficulties engaging, with engagement being defined as the number of appointments they had attended. However, this proved impractical due to the limited time that practitioners were able to offer in terms of identifying mothers and the limits in the available number of mothers.

Of the mothers who were asked to participate by their practitioners, two mothers declined, which the practitioners thought to be due to the mothers' anxiety about the process. Two other mothers did agree to be interviewed but ultimately were not interviewed; one of them repeatedly cancelled pre-arranged interview appointments and the other was repeatedly unavailable to be interviewed or to be contacted by telephone or text. Some of the practitioners requested that mothers' partners (fathers of the baby) were interviewed, as they were working with the mother and father jointly. It was agreed that these fathers would be interviewed, either jointly with mother or separately, depending on preference. All of the couples interviewed chose to be interviewed jointly.

Participants were recruited and interviewed between August 2013 and February 2014. Eight of the participants were recruited from site one, four from site two and four from site three.

**Participant characteristics.** Sixteen mothers and three fathers participated. They had been in the program for an average of 21 months (range = 16 to 26 months). Thirteen mothers did not have partners involved (or involved very minimally) in the MTB programme. The other three, whose partners regularly participated in the programme, were interviewed jointly with their partner. The final sample size was judged to be large enough to provide a detailed and rich data set for analysis (Sandelowski, 1995).

The mothers ranged in age from 17 to 23 years old ( $M=21$ ;  $SD=2$ ) and their babies ranged in age from 9 to 19 months old ( $M=14$ ;  $SD=3$ ). Two of the three fathers involved were aged 21 and the third was 23 years old. All of the participants described their ethnicity as White British. Eleven were co-habiting, and two of the couples had additional children (the fathers' children) who lived with the couple some of the time. Of the remaining five, two mothers were married and the other three were living alone with their baby and described themselves as single. Eleven of the mothers and all three fathers had GCSE level qualifications; three of the mothers had attended some secondary school but had not achieved GCSE level or any other academic qualifications. Two mothers were currently in education (college). All participants were unemployed at the time of the interview apart from one father. Table 1 shows the main characteristics of each parent who participated in the study. Ethnicity and employment status have not been included in the table but are described above.

There were 15 practitioners involved with the 16 mothers and each mother had two practitioners (some shared the same practitioners). All of the practitioners were White British women.

Table 1: Participant characteristics

<b>Participant (Mother = M; Father = F)</b>	<b>Time in MTB (mths)</b>	<b>Participant age (yrs)</b>	<b>Baby's age (mths)</b>	<b>Living arrangements (participant &amp; their baby)</b>	<b>Educational level achieved</b>
<b>M1</b>	21	22	14	Co-habiting	GCSE
<b>M2</b>	21	19	14	Alone with baby	GCSE
<b>M3</b>	18	18	11	Alone with baby	No academic qualifications
<b>M4</b>	19	22	12	Co-habiting	No academic qualifications
<b>F4</b>	19	21	12	Co-habiting	GCSE
<b>M5</b>	20	19	13	Co-habiting plus partner's children (part-time)	GCSE
<b>F5</b>	20	23	13	Co-habiting plus other children (part-time)	GCSE
<b>M6</b>	17	21	10	Co-habiting	GCSE
<b>F6</b>	17	21	10	Co-habiting	GCSE
<b>M7</b>	25	20	18	Co-habiting	No academic qualifications
<b>M8</b>	16	17	9	Co-habiting	In education
<b>M9</b>	19	21	12	Co-habiting	GCSE
<b>M10</b>	26	27	19	Co-habiting plus partner's children (part-time)	GCSE
<b>M11</b>	25	19	18	Co-habiting	GCSE
<b>M12</b>	26	20	19	Co-habiting (married)	GCSE
<b>M13</b>	19	23	12	Co-habiting (married)	GCSE
<b>M14</b>	23	21	16	Co-habiting plus maternal grandmother	GCSE
<b>M15</b>	20	17	13	Living with father and sister	In education
<b>M16</b>	24	19	17	Co-habiting	GCSE

## **Procedure**

Mothers who had expressed an interest in participating were contacted by telephone by the researcher, in order to discuss the research further, to confirm their wish to participate and to arrange a day and time to carry out the interview. Interview dates and times were confirmed through text message and reminder texts were sent prior to the day of the interview. All participants were provided with the study information sheet (see Appendix 4) by their practitioners and were again given it to read just prior to their interview. Written consent (see Appendix 5) was obtained before the interview began and mothers were assured of confidentiality and reminded that the interviewer was independent of the NSPCC who ran the MTB programme.

Given the potential of the research interview to be stressful for participants, this possibility was explicitly acknowledged by the researcher before the interview began, and assurance was given to participants that they could stop the interview at any stage. A debriefing period was included at the end of each interview to talk about how the interview felt for participants and any strong emotions elicited.

## **Interviews**

A semi-structured interview schedule was developed specifically for the study. The interview schedule (see Appendix 6) focused on participants' experiences of MTB. The first area covered was mothers' views of their engagement in the program and what hindered or facilitated this. As the mothers were unlikely to talk, or think, in terms of 'engagement', questions were asked which would make more sense to them, such as: what they liked or disliked (found helpful or did not find so helpful) about the programme, what they talked about with their practitioners, how it was decided what happened in each session, and whether they ever found it hard to keep appointments with their practitioners (and why). In order to find out more about their engagement, the second area covered was the mothers' relationships with their practitioners and what hindered or facilitated these. Again,

questions which would make sense to the mothers were used, such as: how they got along with their practitioners, how the practitioners differed to other professionals, and what it was like to have two of them. The mothers' relationship with each of their practitioners was also explored (in turn). Mothers were asked questions about how they felt during and after home visits with each practitioner and what they liked or did not like about each of them. The last area focused on was the mothers' views of programme outcomes. Mothers were asked questions such as: what it was like to spend time with their baby, whether this had changed over time, and whether the programme had led to any changes in their lives.

In developing the semi-structured interview, established guidelines were followed (Di-Cicco-Bloom & Crabtree, 2006). Consistent with these guidelines, a set of open-ended questions was decided upon. Given the disadvantaged backgrounds and limited educational experience of this particular sample, these questions were kept as simple as possible. As stated above, it was important that questions made sense to the mothers in order to gain their views and opinions of the programme. Short and clear questions were asked, using basic language and concepts participants could easily understand (e.g. 'what do you like about the programme' rather than 'what helps you to engage in the programme'). Prompts and follow-up questions were used to enable elaboration of participants' experiences or views. During the first few interviews, the participants found it difficult to fully understand and answer the pre-determined questions that enquired about their experience of change (e.g. 'What have you learned since starting the programme' and 'Can you think of anything in your life that has changed since meeting your practitioners'). It was hard for participants to comment on these changes as they did not know what would have happened if they were not involved in MTB. Given this, the interview was modified (through discussion with the research supervisors) to include questions about change that were more focussed on what mothers could have a clear view on without having to imagine what might have happened if they were not

involved in MTB (e.g. 'What is it like spending time with your baby?' and 'How has this changed over time?').

Interviews were conducted in the mothers' homes. The interviews with each mother (or couple) lasted approximately 40 minutes (range: 20-76 minutes) and were audio-recorded. In all three cases where a father was involved in the interview, the mother and father were interviewed together. Of the 13 interviews conducted with mothers only, the baby was present in 10. Of the three interviews with couples, the baby was present in two.

### **Data Analysis**

All interviews were transcribed verbatim by the researcher and analysed using the method of thematic analysis described by Braun and Clarke (2006). This involved identifying patterns (themes) within the data set, the main aim being to develop an understanding of the meanings conveyed by the participants, through coding and labelling data. Firstly, each of the 16 transcripts (word documents) was coded using the 'tracked changes' function in Microsoft Word. This involved numbering and reporting on (in comment boxes) every line of the transcript that looked relevant, even if only mildly so, to the research questions. Minimal interpretation was done at this point and participants' own words were mainly used in the codes. Following the coding, the comment boxes were then copied into a table (a separate one for each transcript) in their numerical order and using this table, a summary sheet of the main ideas for that transcript was created. Each of these summary sheets, and associated codes, then fed into the development of some initial categorisation of the data set as a whole, maintaining the complexity and richness of the data set (Braun & Clark, 2006). Similarities and connections within and between these categories were then analysed further (Braun & Clarke, 2006), resulting in the domains, themes and subthemes presented in the results section. Appendix 7 illustrates the steps of analysis.

**Credibility checks.** Given the intrinsic role of the researcher in qualitative research and the potential subjective nature of analysis, it was important that the findings were checked to determine their credibility (Lincoln & Guba, 1985; Schwandt, 1997). In this study, the check used was consensus, which began with the researcher discussing the data with one of her research supervisors, as well as with the researcher on the joint project, throughout data collection. This included the supervisor reading one of the transcripts. The researcher then discussed the initial coding with the supervisor and the second researcher, and presented the supervisor with some of the coded transcripts and tables of codes. The summary sheets were then developed through discussion with the supervisor, as were tentative themes and ideas. There was lengthy discussion and development with the supervisor in order to fine-tune the themes and subthemes (and some discussion of these with the second researcher). This process, involving both another researcher and a supervisor of the research, allowed discussion and presentation of different conceptualisations of the data, before a consensus was then reached.

### **Researcher's perspective**

My experience before starting this study did not include any involvement with parenting programs. However, I had worked closely with parents and their infants (and older children) in the role of a psychological assessor. This involved gaining information on psychological functioning (both of the parent and child) and parenting ability, to be presented in court during local authority care proceedings. I had also worked with parents whilst providing therapy (both psychodynamic and cognitive behavioural) to their children; however this had again been mainly focused on assessment (of the child). I had no experience of working therapeutically with parents to improve their reflective functioning, specifically in relation to their child. However, given my experience as a therapist and my theoretical knowledge of the therapeutic relationship and reflective functioning, I began this study aware of my assumption that the practitioner-parent relationship was likely to be the main driving

force for engagement in the programme and any change in reflective functioning. In light of the parents being from disadvantaged backgrounds and experiencing multiple adversities, I expected that they would have some difficulty articulating their experiences of engagement in the programme and of outcomes.

## **Results**

The analysis produced 10 central themes (each of which included several subthemes), organised into three domains (Table 2). The first domain describes the parents' perception of any changes brought about by their involvement in the MTB programme. The second and third domains describe the aspects of the MTB programme and characteristics of the practitioners, which helped parents to engage with the programme and helped to bring about change. The perceived changes (i.e. the first domain) are presented first, as they provide the context for parents' perceptions of what facilitated these changes. The themes represent the views expressed during the 16 interviews, which include the three interviews with couples. Given this, the participants are referred to as 'participants' or 'parents' for the remainder of this report, unless specifically discussing the mothers or the fathers. Each theme is illustrated with quotations, and the participant's research identification number indicates the source of each quotation; M is used to indicate a mother and F to indicate a father.

### **Domain 1: Perceived changes**

Involvement in the MTB programme produced an experience of change for almost all of the parents. This was not described in the same depth and detail as the parents' experiences of the programme and their practitioners (Domains 2 and 3), but there were some clear areas where change was commonly perceived to have occurred.

Table 2: Themes and subthemes

Theme and Subtheme	Prevalence (n=16)
<b>Domain 1: Perceived changes</b>	
<b>1.1 Changes in parenting skills</b>	14
Learned about baby's development	9
Learned skills to manage baby's behaviour	4
Understanding baby and their behaviour	2
<b>1.2 Changes in self</b>	8
Confidence	4
Wellbeing and mental health	4
<b>Domain 2: Characteristics of the programme</b>	
<b>2.1 Flexible and tailored to individual needs</b>	16
"There for me"	15
Fit visits around me	5
Telephone contact between visits	4
Support before and immediately after birth	4
<b>2.2 Collaborative</b>	12
Goals	6
Work with me and baby together	9
<b>2.3 Information and guidance</b>	15
Provide advice and direction	13
Developmental checks/reviews	10
<b>2.4 Practical help</b>	9
Help with housing and goods for baby	6
Help with financial difficulties	3
<b>Domain 3: Characteristics and qualities of the practitioners</b>	
<b>3.1 Mutual trust</b>	14
"They trust me"	7
Trustworthy	10
<b>3.2 Non-judgemental and supportive</b>	12
Understand and accept me	9
Reassure me	12
<b>3.3 Relaxed and open</b>	12
Like family or friends	6
Easy to talk to	11
Funny	10
<b>3.4 Personal experience of parenthood</b>	5
Understands parenting	2
Supplementary advice	3

Participants spoke about the development of their parenting skills, mainly reporting increased knowledge of how babies develop and how to manage specific behaviour their babies exhibited. They also identified positive changes in how they felt, both about themselves and about caring for their baby.

### **1.1 Changes in parenting skills**

Nearly all parents mentioned some changes in their parenting skills. Through the developmental reviews completed by the practitioners, as well as the general information and guidance provided, parents described learning more about the stages of development for their baby and learned skills to encourage and support this development.

*They like, encourage her [baby's] development, they will like say when she is pointing to stuff for me to say what it is to help her talk. So if she [baby] is pointing outside to a tree [the practitioners told me] to say 'are you pointing to a tree' and stuff like that. (M11)*

As demonstrated by the above quotation, this mother noticed how the practitioner was 'speaking for the baby', a core part of the programme in terms of supporting reflective functioning; however, the mother interpreted this more concretely, as the practitioners labelling things for her baby to learn, i.e. supporting their development.

Through their provision of relevant information and guidance, the practitioners supported participants to learn skills to manage their child's behaviours. This included managing sleeping problems (e.g. moving the child to their own bedroom) and tantrums.

*A few things they have suggested; when she [baby] was 3 months old she just wanted to sleep in bed with us all the time. To try and get her out of it I had to leave her in the cot to cry or not talk to her when I went in the bedroom, or not pick her up, and it did work. (M4)*

*Baby is now past one [year old] and she does have [tantrums] and I have no idea how to react to them . . . [the practitioners] say 'look, you just have to distract her' and that is what I do now, it's really easy actually. (M15)*

An improved understanding of their baby and his/her behaviour was alluded to in the parents' descriptions of learning skills to encourage their baby's

development and to manage their behaviour. Two participants gave more explicit accounts of understanding their baby.

*I just think it's been a bit easier like learning that sometimes he'll [baby will] cry for no reason and that he can have night terrors and stuff. (M1)*

*Like before I was a bit set back and I didn't know what I was doing [with baby]. I didn't really think about things as much but now everything I do I think 'right if I do that [what will it mean for baby?]'.* (M16)

The second quotation above also demonstrates how the mother felt that practitioners supported her to feel more confident in relation to caring for her baby. This subtheme is described further in the next section.

## **1.2 Changes in self**

Half of the parents described changes in themselves. For some of these parents, a key area of change was in their confidence, particularly in relation to caring for their baby. They described feeling more like they were being good parents, who were providing their babies with appropriate care. Parents attributed changes in their confidence to their relationships with the MTB practitioners, particularly referring to the reassurance and support practitioners provided (see Domain 3; Theme 3.2). Some of the parents felt that these positive aspects of their relationships with MTB practitioners were not present in the relationships they had with other people, such as family members.

*We feel a bit more confident in what we do [now] because we know we have them backing us up and in our corner . . . that's nice because we don't always get that from our family. (M14)*

*She sort of helped me relax with that [baby's health], so now if baby has a cold I know it's just a normal cold . . . whereas before if he had a cold I would be panicking and would probably rush him to hospital. I used to be really bad and she has helped me calm down a lot with that. (M12)*

Personal wellbeing, and managing personal difficulties, was a second area that some participants found to have improved through their experience with MTB. They appreciated the time and attention practitioners had given to their difficulties, either providing the support themselves or helping participants to access appropriate

services (e.g. supporting a mother to attend GP appointments). Some parents (as demonstrated by the quotations below) felt that the practitioners supported them in how they were thinking about themselves and their baby, helping them to manage negative or unhelpful thoughts they were having about themselves or their babies.

*Just coming out of the pregnancy, I blamed myself for being poorly and for baby being premature, because my body didn't agree with it. [I thought] it's my fault that he came out small, but [also] other things out of my little family to the big picture of the family; she [the practitioner] has helped me a lot with that. (M12)*

*I just suffer from depression at the moment so [the practitioner] has been helping me go to the doctor appointments and stuff like that . . . I like also getting information about anxiety . . . and then talking through that [with the practitioner]. (M9)*

## **Domain 2: Characteristics of the programme**

The parents talked about some specific aspects of the programme that had encouraged their engagement in it and facilitated the changes described above. The programme's flexible, individualised, informative and collaborative approach made parents feel like their particular needs were being attended to and met, and that they were fully supported. Some of the parents spoke of some wariness about participating in the programme at first due to the NSPCC and the practitioners' professional titles. This was due to parents' perceptions of the NSPCC and/or their experiences of professionals; however, all of these parents reported that, once they met their practitioners and spent time with them, they were no longer concerned.

### **2.1 Flexible and tailored to individual needs**

All parents valued the flexible nature of the programme and how it was tailored to their individual needs. They spoke of practitioners being there for them when they needed them and supporting them in the ways they required. This included fitting visits around parents' availability and preferences, and also being available by telephone between visits.

*Just knowing that they are there for you if you need any help, if you have any questions or anything . . . they are quite flexible as well, they might just give me a phone if they are sometimes even in the area [and then] they can just*

*pop up or whatever . . . If I have any questions I need to ask . . . I can just phone them and ask and they will be there for me. (M13)*

*[The practitioners are] there if you ever need a chat or anything . . . if I need to talk to anyone and I can't talk to my partner, then I have them to talk. (M10)*

Some parents particularly appreciated the support that MTB had provided before the baby was born, in terms of preparation for the birth and training in basic skills required to care for the baby. These mothers also appreciated the MTB practitioners visiting whilst they were in hospital having their baby and implied that they felt practitioners really cared and were willing to put in the extra effort to support them and their baby.

*When I was pregnant . . . any fear or concerns we had about the baby . . . you know like they helped me write a birthing plan and things like that . . . explained a lot of stuff showed me how to bath a baby, how to breastfeed . . . they came and visited me in hospital . . . they didn't have to do that, it was really nice having them. (M14)*

## **2.2 Collaborative**

Many parents appreciated the collaborative nature of the programme, particularly in relation to setting goals. Practitioners helped them to set goals, mainly related to what they wanted to achieve in their parenting, and then supported them to fulfil these goals. Parents found it satisfying to achieve these goals, which enhanced the development of their parenting skills.

*Last time . . . I was speaking to her [the practitioner] about baby because she was still in the cot in the bedroom with us and I set a goal for getting baby into her own room and getting her off bottles . . . through the night. So when they [the practitioners] came up yesterday I had got her into her room the night before, so I said 'the next time I see you I will have her in her own room' and I done it. (M13)*

Another area of collaboration that parents found useful was the way the practitioners encouraged and facilitated the interaction between them and their baby. Parents especially highlighted their enjoyment of the activities the programme facilitated (e.g. going to the park, painting and creating a scrapbook) to enable this interaction. Participants felt that this was different to their experience of other

services who were interested in either them, or their baby, rather than the interaction between them and their baby.

*It [MTB] is all about me and my baby, not about meetings I have to go to or if baby is alright. It is all about [the] fun and activities me and her can bond [over] and what we can do together, so she can stay focused and what not. It is all basically around our relationship and nothing else and that is what I like. (M16)*

The importance of this collaborative style was demonstrated by one mother's experience of an absence of collaboration. In the interview she expressed anger and confusion about one of her practitioners not working together with her and her baby; she felt that the practitioner just played with the baby all of the time and did not talk to, or include, herself.

*[The other practitioner] does more, [this practitioner] just doesn't. I'm wanting to get her [the baby] to benefit out of it [MTB], not just get her to sit there and play all the time... when they were both in [coming to visit together] she [the practitioner] didn't talk [to me] it was just [the other practitioner] talking, going through everything and I was going 'why are you here if you don't want to talk?'. (M3)*

### **2.3 Information and guidance**

Nearly all parents valued the information, direction and advice provided to them by their practitioners. This included advice about cooking and what to feed their babies, as well as a lot of support with the health needs of their babies. Parents spoke of being able to ask one of their practitioners (the paediatric nurse practitioner/health visitor) anything about the health of their baby (e.g. nappy rash, coughs, colds) and knowing that they would get useful advice or information back from that practitioner.

*She's helpful, she knows a lot about everything to do with babies and their health . . . feels like more or less anything you ask her about baby's wellbeing . . . she'll know and answer. (M2)*

*If we . . . have got any questions about baby's health or nappy rash or something like that then [we] can always ask [the practitioner] for like information about it and [the] best advice [about how] to get through it. (M4)*

Some parents also talked about valuing the advice and information provided by the programme for more personal issues, such as their relationships.

*They helped me see the bad things [in a previous relationship], at the time I didn't realise, I was like whatever but . . . they made me realise and obviously they helped in my relationship I am currently in now . . . they will explain things to me. They are really helpful when it comes to my relationships. (M16)*

The development reviews carried out by the practitioners were considered very useful by many of the parents. They felt that these reviews helped them to learn about the development stages of babies, and how babies can develop different skills at different times or rates. This reassured parents that their baby was normal and supported them in promoting their baby's development.

*We [the practitioners and I] have done a development thing where they have asked me questions about what certain things she [the baby] can or can't do, things like that, and ways to work on it and improve in a certain area if [baby] struggling a little. (M14)*

*I talk to them about her [the baby] development . . . I can sometimes get a bit worried about how she is developing and they reassure me that she is doing good. (M11)*

## **2.4 Practical help**

The practical help provided by the practitioners was important to some of the participants, in particular those experiencing housing problems, or difficulties providing their baby with food, clothing and safety equipment (e.g. safety gates). The parents appreciated the help, which they described as very effective, that the practitioners had provided in resolving their particular practical issues.

*Just before we met them we was living at my parents' house and we didn't have nowhere to go or anything like that . . . They automatically helped us to get a place with the council . . . They helped us to move in our stuff and everything. When I was in hospital, they helped us to clean the flat and everything, make it safe for her [the baby] too. (M9)*

Some participants also found the practitioners helpful in assisting with their financial difficulties, such as debt resolution.

*She will be assertive to the CAB [citizens advice bureau] to try and get them to talk to people. Last time we did it [debt resolution] through CAB and only managed to get the interest to stop for a month but this time it's stopped for good until we have paid it all off . . . so I think [the practitioner] has been more assertive, like they need to listen and to stop the interest. (F4)*

*She does most of the talking [at CAB meetings], she knows more about my debts than what I know . . . I feel a lot more comfortable going to the CAB*

*with her than without her . . . she tones it down from CAB talk to my lingo.*  
(F5)

### **Domain 3: Characteristics and qualities of the practitioners**

A crucial feature of the programme for many of the parents was the relationship between them and their practitioners. Participants spoke of the characteristics and qualities that they valued in their practitioners, and which combined to create the close relationships they felt with them. These close relationships, alongside the parents' positive experience of certain characteristics of the programme, seemed to facilitate the participants' engagement in the programme and led to the changes that parents reported to have occurred.

#### **3.1 Mutual trust**

For most of the participants, trust was an important feature of their relationship with their practitioners. Around half of the parents spoke of appreciating the trust that their practitioners placed in them. They felt that practitioners trusted them to make their own decisions, providing guidance and advice rather than just telling them what to do. This went side-by-side with the collaborative nature of the programme described above.

*There's such level of trust there that, unless there is something immediate that needs dealing with, she will kind of leave us to devise our own kind of plans with it and she will be like 'call us if you need us'. (M1)*

Parents also found their practitioners trustworthy; they described feeling able to talk openly with them about most things, such as difficulties they were having personally or with their baby. Some parents also noted how they usually found it difficult to trust others but had been able to build a trusting relationship with their MTB practitioners. They explained that this was due to the positive way in which practitioners related to them.

*I have been through quite a lot with baby's dad and I tell them everything about it and just rant to them about it sometimes. So yeah, I do really trust them because I know I can speak to them and it will just stay between us unless it's something dangerous but no, I can definitely trust them. (M15)*

*[The practitioner] has always been really nice and genuine towards us and she has built that level of trust up with us, I mean me and my partner do find it very difficult to trust anyone. (M14)*

However, one mother felt she could not fully trust one of her practitioners, and did speak of feeling judged by her. This perception contributed to the mother's wish to have only one practitioner, highlighting the importance of trust, and acceptance, in the parents' relationships with their practitioners.

*[I] can trust one of them but not the other one really . . . because of my age I think she thinks I am wrong, that's how I feel. I feel like she looks at me as if to say 'you don't understand the world because you are a so and so' . . . the only thing I would change [about the programme], [would be to have] just one [practitioner]. (M16)*

### **3.2 Non-judgemental and supportive**

The non-judgemental and supportive stance of their practitioners was important to many participants. They described this in terms of how the practitioners understood and accepted their particular difficulties and needs.

*I've spoken to her about stuff before and she's not judged. (M1)*

*. . . they [the practitioners] really understand everything like the situation between me and the baby's father, like they get it...I can talk to them about it all and they will understand it. (M15)*

*[I] feel like they just accept me for who I am, for definite. (M9)*

Related to the practitioners' understanding and acceptance, most of the parents felt that their concerns about parenting, their baby and themselves were helpfully supported through their practitioners' provision of reassurance. They felt reassured by their practitioners that they were being good parents, that they were able to provide the right care to their children, and that there were other mothers who had similar experiences to them (i.e. they were not alone in their struggles).

*Baby was in an incubator for 6 hours which doesn't sound like a lot but . . . I felt like I wasn't going to bond with him . . . [The practitioners] really supported me through that [telling me that] there will still be that bond and [now I feel that] there will always be that bond. (M1)*

*[The practitioners have] been saying that we have been really good parents towards him [the baby] and they can see it in his stages of development and how he is progressing . . . she [the practitioner] always tells us to relax and that. (M6)*

### **3.3 Relaxed and open**

For many participants, the relaxed and open nature of the relationship with their practitioners was crucial in helping them to feel comfortable and at ease. Participants reported that they often felt this way very early on in the relationship due to the positive way practitioners related to them right from the beginning. Parents likened the relaxed relationship they had with their practitioners to relationships with friends and family.

*Feels like they are kind of family now . . . I can actually just lie back, relax and be honest. (M6)*

*I have gotten used to them coming round now, like having family or friends visiting... [the practitioners] sit down and talk to me as if we are some sort of friend so that [is] nice. I feel comfortable around them. (M12)*

In relation to this, participants felt that practitioners were easy to talk to, enabling them to talk openly with them, sometimes about topics that they found difficult to discuss with others. Some of the participants spoke of feeling more comfortable talking to their MTB practitioners than to other professionals.

*I have talked to them about things that I've not even spoken to my husband about and they have helped me out with them and helped with some understanding of them as well. (M12)*

*It [the MTB programme] is just a better environment [than with other professionals] and stuff I would prefer talking to them than anybody like a doctor and that. (M15)*

A number of the participants also talked about their relationships with the practitioners as being humorous and fun. They described how this helped them to feel relaxed in their company and to enjoy their visits.

*She is funny [and] has a laugh all the time . . . not boring, if she was boring I don't think I'd like to see her that much but she isn't, she is [really] funny. (M7)*

### **3.4 Personal experience of parenthood**

The practitioner's own experience of being a mother was considered to be important by some parents. Two mothers felt that their practitioner having personal

experience of being a parent meant that she could better understand what it was like to parent and, hence, what they were feeling.

*Obviously with her having kids and she understands parts of what I feel . . . she understands when I overreact about stuff. (M9)*

*She knows what its like, how they [children] can do your head in. (M5)*

For some of the parents, the practitioner's experience of being a parent meant that they could get personal (as well as professional) views and advice on what they should be doing with their child. They found this personal opinion helpful as a supplement to the professional advice and information they were gaining from their practitioners.

*She can give me her opinion on things with her [the baby] using stuff from her kids so she can talk about her own kids and give me the experience she has had with certain things, she can recommend certain products or certain childcare for college and stuff like that, quite handy because she is a nurse and had her own kids. (M8)*

*I can talk to [the practitioner] about most things to do with baby that I have no idea about. She will say her personal view as well because she has children, she will say 'this is what I did', so that is really good as well. (M15)*

## **Discussion**

The parents in this study were from disadvantaged backgrounds, experiencing multiple adversities such as poverty, physical and mental health problems and significant housing and employment problems. They also tended to be socially isolated and have difficulties in their interactions and relationships with others. Despite this, overall, the parents were positive about their experience of MTB, valuing particular aspects of the programme and characteristics of the MTB practitioners. These factors seemed to facilitate their engagement in the programme and enabled subsequent changes to occur. Parents perceived changes in both themselves (confidence and wellbeing) and their parenting (knowledge, skills and understanding).

Key features of the programme valued by participants were its flexibility, its individualised approach and its collaborative nature, as well as the information,

guidance and practical help that the practitioners provided. Parents felt that the programme took into account their individual needs and circumstances and they found the atmosphere of collaboration quite different to what they had experienced from other services. Furthermore, the focus on the mother-baby dyad was experienced as helpful and different to other services, which parents felt had either focused on them or their baby, rather than on them as a dyad.

Parents' perceptions of the programme closely mirrored the principles outlined in the MTB service delivery model (Sadler et al., 2013). Although there is a comprehensive manual for MTB (Slade et al., 2010), a flexible and individualised approach is used to implement the programme, in line with the complex and varying needs of the young parents involved (Sadler et al., 2013). Collaborative activities are used as a way of fostering the development of reflective functioning through supporting parents' enjoyment of their babies and allowing practitioners to narrate the feelings being expressed by parents and babies (Sadler et al., 2013). This match between what the parents valued about MTB and the service delivery model suggests that the design of MTB is well tailored to these parents' needs for a collaborative, flexible and individualised approach.

Parents also valued certain personal characteristics and qualities of the MTB practitioners. They felt that their practitioners were trusting of them, trustworthy, understanding, reassuring, relaxed and open; these characteristics led to the development of close and trusting relationships between the parents and practitioners. The relationships they described can be conceptualised as strong therapeutic relationships, which are developed through an open and collaborative alliance between therapist and client (in this case, the practitioner and the parent) and are crucial to the success of a therapeutic intervention (Lambert & Barley, 2001; Rait, 2000; Sexton & Whiston, 1994).

It is striking that parents were able to develop the strong therapeutic relationships with their MTB practitioners that they described, given that they were

likely to have had poor attachment histories (Carlson, 1998; van IJzendoorn, Schuengel & Bakermans-Kranenburg, 1999) and thus limited social competence and ability to form meaningful relationships (Sroufe, 2005). In MTB, the therapeutic relationship is central, in terms of its role in supporting the progressive enhancement of reflective functioning in the mothers (Slade, 2006). The MTB practitioners' aim is for a mother to feel she is being viewed as a meaningful, well-intentioned and rational person. Given the value that parents placed on the therapeutic relationship and their appreciation of the way practitioners made them feel, it again appears that the focus on the therapeutic relationship and on empowering parents within MTB was well suited to the needs of these parents.

Some parents also valued their practitioners being parents themselves and thus having personal experience of solving problems and making decisions in relation to the care of a child. Borkman (1976) has suggested that those who have been through similar experiences hold "experiential knowledge" (knowledge based on personal experience) which is distinct from "professional knowledge"; the former is valuable in terms of the ability to empathise and the credibility of the advice that is provided. For these parents, this characteristic of their practitioners was in line with what they felt they needed from the MTB programme.

Parents perceived certain common outcomes of the programme. They felt that their confidence and wellbeing, including their management of personal difficulties, had improved. This is consistent with previous research showing that the psychosocial health and wellbeing of parents, including their self-esteem, self-confidence, self-efficacy, anxiety and depression improves following their involvement in parenting programmes (Barlow, Coren & Stewart-Brown, 2002; Coren, Barlow and Stewart-Brown, 2003; Nowak & Heinrichs, 2008). However, the RCT evaluating MTB (Sadler et al., 2013) found that it was not beneficial in improving mothers' wellbeing. Considering this unexpected finding, Sadler et al. (2013) suggest that their main measure of wellbeing, the Centre for Epidemiological

Studies Depression Scale (CES-D; Radloff, 1977) may not have adequately measured wellbeing in their sample. They hypothesise that many of the mothers in their study were experiencing complex trauma (Courtois, 2008) which is difficult to formally assess but is likely to impact upon wellbeing. Given the difficulties assessing the underlying trauma (Courtois, 2008), typical measures of wellbeing may have been poorly suited to the mothers involved in MTB (Sadler et al., 2013).

As well as the CES-D, Sadler et al. (2013) used the Brief Symptom Inventory-Short Form (BSI; Derogatis, 1993) and the Parental Bonding Instrument (PBI; Parker, Tupling & Brown, 1979) to measure the wellbeing of mothers. The CES-D and BSI are both symptom measures and the PBI is used to assess mothers' experience of care and protection from their own mothers. None of these measures is likely to be well suited to measuring the mothers' confidence or their management of personal difficulties. The qualitative approach of the current study allowed greater exploration of changes in the parents' wellbeing than was possible in the Sadler et al. (2013) RCT.

Parents also felt that their parenting skills had improved due to MTB; they reported learning about their child's development and also how to manage the behaviour of their child as he/she developed. Although these outcomes could imply some improvement in the parents' ability to reflect on their babies' internal states, this was not stated in a concrete way by parents during the interviews. This is perhaps unsurprising given the complexity of reflective functioning as a concept and therefore the level of thinking and language required to recognise and articulate change. In the absence of concrete accounts of changes in reflective functioning, it is difficult to know whether any change occurred and if it did, to what extent. It is possible that parents were actually still quite limited in their ability to be thoughtful about their child and may have been continuing to rely on the practitioners' assistance in understanding their child (despite most of them nearing the last six months of the programme). Alternatively, it is possible that the parents' reflective

functioning had improved in line with MTB aims but that parents were unable to clearly articulate or recognise these changes as improvements in their reflective functioning. In the recent RCT of MTB, Sadler et al. (2013) found that changes in reflective functioning, as measured by the Pregnancy Interview and Parent Development Interview, were limited to a small subset of their sample, those mothers with the lowest educational level and very low reflective functioning at the start of the programme.

### **Study limitations**

The findings of this study cannot be generalised as the participants were those who were engaging well with the programme. It was not possible to explore differences in the experiences of those parents who were engaging well, compared to those who found it more difficult to engage. Specifically, it was not possible to explore the factors that hindered engagement or change.

Given their disadvantaged backgrounds and generally low levels of education, it is likely that the parents had some difficulties articulating their experiences during the research interviews. In addition to this, they were being asked about their experiences of engagement and change, which are difficult to reflect upon. Some of the parents reported difficulties trusting others that may have also impacted upon their willingness to talk about their experiences to a researcher who was unknown to them. The parents may have also been reluctant to talk about negative experiences of the programme due to concerns that the researcher would pass this information on to their practitioners. However, despite these likely barriers, participants did give quite detailed accounts of their experiences.

### **Clinical implications and future research**

The parents' experiences of what facilitated their engagement in the programme and subsequent change are important when considering the optimum ways to engage young, disadvantaged parents and to facilitate desired outcomes. Individualised, flexible, collaborative programmes that involve the development of

non-judgemental, supportive, open and trusting relationships between practitioners and parents seem fundamental to engagement and change. Mutual trust in relationships with practitioners seemed to be a crucial factor for these parents; this has implications for professionals working with young, disadvantaged parents.

The capacity of young, disadvantaged parents to trust professionals is not typically an outcome measured in quantitative studies of parenting programmes. However, given these parents' difficulties with trust, and its impact on their relationships (with professionals and others) and thus engagement, an improvement in their capacity to trust could be considered an important outcome. The incorporation of a measure of trust in future research would enable further exploration of the impact parenting interventions have on disadvantaged parents' capacity to trust others, particularly professionals.

It is important that future research explores the experiences of parents who have difficulties engaging in parenting programmes, such as MTB, in order to understand the factors that hinder engagement and thus change. This would facilitate further development of parenting programmes to address these issues. Additionally, future qualitative research exploring parents' experiences of MTB would benefit from conducting interviews at multiple time-points. This would provide more detailed information about engagement and change throughout the duration of the programme that would again facilitate programme development and outcomes.

## **Conclusions**

The perceptions of the parents in this study suggest that engagement and subsequent change in MTB is promoted by the individualised, flexible and collaborative nature of the programme, as well as the close and trusting relationships between parents and MTB practitioners. The changes parents perceived were in their confidence, wellbeing and parenting skills. The parents were generally engaging well in the programme, so little is known about the factors that hinder engagement and change; this is an area for future research. This study

suggested several factors that are important to the success of interventions with young, disadvantaged parents. Trust was crucial in the relationships parents had with their practitioners, and thus was crucial to their engagement and change. It is important that future research explores the impact that interventions have on young, disadvantaged parents' capacity to trust others.

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### **Part 3: Critical Appraisal**

## **Introduction**

This critical appraisal reflects on the process of designing and conducting the research presented in Part 2 of this thesis. It discusses particular challenges that were encountered and ways in which these challenges were addressed. Issues in analysing the data collected through the interviews are also discussed.

### **The potential impact of previous experience on research**

Researchers inevitably bring their own ideas, values, beliefs and previous experiences to the qualitative research process (Krefting, 1991) and these can influence the collection of data, as well as the interpretation and presentation of it (Fischer, 2009; Tufford & Newman, 2010). Reflexivity is therefore important in qualitative research, helping to highlight the factors that may be influencing the research (Willig, 2008).

“Bracketing” is thought to be important in limiting the negative impact researchers’ preconceptions may have on research; it is conceptualised as the recognition and attempted ‘setting aside’ of preconceptions (Fischer, 2009); however, there is debate about whether bracketing is truly possible, when it should occur in the research process and what should be bracketed (Tufford & Newman, 2010). Bracketing involves a process of the researcher reflecting on their ideas, values and beliefs (Ahern, 1999). Tufford and Newman (2010) propose that, rather than just ‘setting aside’ these preconceptions, bracketing can enable them to be evaluated in terms of both their possible positive and negative influences on the research process. In the following section I will reflect on my previous experiences of working with disadvantaged parents and how this influenced my preconceptions and ideas about the research carried out with parents in the Minding the Baby programme.

### **Previous experiences**

Prior to beginning my training as a clinical psychologist, as an assistant psychologist I had an experience of trouble parents that was negative and one-

sided. My role involved conducting psychological assessments of children and parents involved in local authority care cases. In general, these cases involved discussion about whether there should be a removal of the children from the care of their parents into either long-term foster care or adoption. The psychological assessments were court-ordered and carried out independently from any of the parties involved in the case.

The local authority cases tended to present (in the files which we read pre-assessment) parents in a negative light and, compounding this, the parents were frequently (understandably) defensive, argumentative and challenging to engage during psychological assessments. The parents often had poor relationships with social services and they were wary of professionals and services in general; they often considered the psychological assessment to be designed to gather further evidence to condemn their ability to parent. Although their suspicion and animosity was understandable in the context of their situation, it provided me with a quite negative experience of these parents.

Based on my time assessing these parents who experienced considerable adverse social circumstances, I had some preconceptions about the parents I was going to be interviewing in the current study. My expectations were also partly shaped by research on parenting interventions indicating that services and professionals often have difficulties engaging disadvantaged parents (Lundahl, Rissu, & Lovejoy, 2006; Reyno & McGrath, 2006). This can be due to the parents' past experiences of services and general difficulties forming relationships and trusting others (Sroufe, 2005). Given possible issues with trust, I also expected that the parents might find it difficult to talk openly and be overly concerned with confidentiality. In addition, I thought it likely that the parents' ability to understand and answer the interview questions would be negatively impacted upon by their disadvantaged backgrounds and inconsistent or limited schooling.

## **Challenges in designing and conducting the study**

When reflecting upon the impact of my previous experience, I considered both the potential positive and negative influences on the research. In terms of the possible negative influences, I was concerned that my preconceptions would lead me to make assumptions about recruitment (e.g. recruiting mothers would be very difficult) and interviewing (e.g. mothers would not be able to interact or engage with me and would not be able to articulate their experiences or understand the interview questions). In an attempt to limit this, I kept a research journal in which I reflected upon my thoughts and observations during the research process (Cutcliffe, 2003; Glaser, 1998). Some examples of the impact of this reflection occurred during recruitment and the interviews. I observed that, although recruitment took longer than expected, this was not due to the parents but actually to practitioners who were often limited in the time they had to discuss the research with the mothers. Furthermore, during interviews I noted that parents were more able than I had expected to interact with me and to express their views.

Reflecting upon my preconceptions and beliefs also helped me to identify and understand how they could have a positive influence on the design of the research (Tufford & Newman, 2010). This included considerations about developing the interview schedule, as well as how to go about recruitment and the home visits to conduct the interviews in such a way that was most appropriate and effective.

### **The process of recruitment**

In terms of the recruitment process, practitioners were the first people to introduce the research to mothers and they then gained the mothers' consent to be contacted by me. Having a trusted individual introduce the research aimed to bridge contact between the mothers and the researcher, limiting the barriers (particularly in terms of trust and relationships) that I expected to exist when recruiting these mothers. Most of the mothers informed about the research by their practitioners

agreed to take part and I think this was aided by having someone whom they trusted introduce the research (Demi & Warren, 1995).

In light of my expectations of the mothers' difficulties in trusting professionals, I tried to introduce myself via a telephone call to all of them prior to the interview. I also sent the mothers reminder text messages, normally a few days prior to the interview and on the day of the interview. This short telephone contact and the text messages aimed to maintain the mothers' involvement once they had initially given consent. It was designed to provide some connection between me, as the researcher, and the parent and also to make it a little easier for parents (particularly the telephone contact) during a face-to-face interview. Most of the mothers who agreed to participate when told about the research by their practitioners remained involved through to completion of their interview.

### **Designing the interview schedule**

Given the generally low levels of education of mothers enrolled in Minding the Baby, the semi-structured interview schedule was designed to be clear, concise and simple. This meant that the interview questions were carefully considered in terms of the language used, the length, complexity and concepts being asked about. Questions were kept short, asked about one idea at a time and used simple, clear language; the central aim was to make it easy for the parents to understand what was being asked and therefore to be able to express their views.

The structure of the interview was also important in terms of gaining and maintaining the attention of the parents. The interview began with open, general questions about the programme before progressing to more specific questions about their relationships with practitioners and any changes they had experienced as a result of the programme. This design is in line with the methodological literature on designing semi-structured interviews (Barker, Pistrang & Elliot, 2002) and aimed to allow parents to become engaged in thinking and talking about the programme more generally first, before asking them more specific questions, requiring more thought.

The interview was designed to be fairly short in length (about 1 hour) to make it easier for parents to remain engaged.

### **Conducting the interviews**

During the interviews I expected that parents might find it difficult to be open with me, due to social difficulties and concerns about confidentiality. Therefore, I tried to build some rapport with them both prior to, and during, the interview. I also explained the issue of confidentiality (prior to the interview) as clearly as possible, checking that parents understood it and I made it clear that they could ask for a break at any point or ask me any questions they had. Parents often appeared a little anxious generally and unsure of my role, the purpose of the research or how I was connected to *Minding the Baby*. Spending time building rapport and explaining confidentiality seemed to alleviate some of the parents' anxiety and enable them to relax more.

When conducting the interviews, I aimed to help the parents understand what was being asked, and to make it as easy as possible for them to give a full and detailed account of their experiences. The ways I tried to do this were through using prompts to facilitate further discussion and reflecting back parents' accounts of experiences to them (in summaries), to prompt any further ideas and to let them know that I was listening and interested. This style of qualitative interviewing, where researchers prompt, reflect back, actively listen and show interest, is thought to be an effective way of allowing in-depth exploration of respondents experiences (Barker, Pistrang & Elliot, 2002). Parents were responsive to prompts and summaries during interviews, often allowing them to elaborate on their views or opinions. However, there still appeared to be limits in what the parents were able or willing to say. There were several factors that seemed to influence how open parents were and how much detail they were able to give about their experiences; these related to the areas covered in the interview schedule, where the interview took place and who else was present.

**The interview schedule.** Parents found it more difficult to answer questions about how they had changed as a result of Minding the Baby in comparison to questions about their relationships with practitioners; their answers to the former were shorter and less detailed. These questions were actually revised following the first few interviews as parents were finding it difficult to answer them. This was likely due to them being too abstract and hypothetical (e.g. 'What have you learned since starting the programme') and they were changed to be more concrete, experiential and focused on the present ('What is it like spending time with your baby'). However, the concept of personal change is quite abstract by nature and hard to reflect upon. This may be particularly true for new parents, who are focused on their baby and have many other things going on in their lives. In contrast, the questions about parents' experiences of the relationships with their practitioners presented a more concrete concept. Also, given that these relationships were fundamental to the parents' experience of the programme, they were perhaps easier for the parents to talk about.

**Interviewing parents in their own homes.** Another factor which seemed to influence the parents' openness during the interviews was the setting in which I conducted them. All of the interviews were conducted in the parents' homes. This setting was both challenging and helpful. In terms of challenges, there were often other people present in the home during the interviews (who were not involved in the interview); the baby was almost always present but there were also sometimes other family members. This could present a distraction for the parent and also limit how open the parent could be with their opinions and views. In addition, some parents became distracted during interviews by the doorbell, telephone ringing or their television.

To try and limit distractions and interruptions, I asked parents to turn off televisions when possible (sometimes they were using the television to distract their child whilst we talked so they were reluctant to turn it off), and also asked them to

limit (or cease) using their phone during the interview. In terms of other people being in the room where we were conducting the interview, I found it more difficult to manage this and tended to not address it. I could see, from the parents' point of view, having a family member present might help them feel more comfortable with a stranger in the house or to help look after the child.

The main advantage of interviewing parents in their home was that it enabled me to gain a greater understanding of the context in which they were living. This helped me to make sense of their accounts and brought their experiences more to life (e.g. meeting their child, or other family members who they were talking about in the interview).

**Interviewing couples.** In relation to meeting important others in the parents' lives, three of the interviews I conducted actually included the father of the child. Practitioners asked if I could interview both the mother and the father in these three instances, either due to the practitioner feeling this would be useful (as the partner was very involved in the programme) or due to the partner requesting to be involved in the research. Although they were given the choice of being interviewed separately, all three of the couples chose to be interviewed together. There were advantages and disadvantages to this.

In terms of the advantages, it was important and interesting to have the opinions of fathers, who are so often excluded from parenting research and indeed parenting programmes or interventions. In addition, in one of the couples both the mother and father were open and articulate about their experiences, allowing insight into their experience of participating in the Minding the Baby programme as a couple. The disadvantages of interviewing couples together were more prominent for the other two couples. In both cases, the mother in the couple was much quieter than the father during the interview and it was the father who answered most of the questions with some sign of agreement from the mother. I attempted to increase the involvement of these mothers by directly asking for both the mother's and the

father's views and prompting the mother for her opinion at times when only the father had stated his; however, this was not very successful in eliciting more information from the mothers. This meant that it was not possible to gain as much information about these mothers' experiences as may have been possible in an individual interview.

**Interviewing as a clinical psychologist.** As well as the setting of the interview and who was involved in the interview, the process of conducting interviews was likely impacted upon by my role as a clinician. Given that some of the parents spoke about difficult experiences, both past and present, I found it was challenging not to slip into the role of being a clinician and trying to help them. I had to remain aware of my role as a researcher and what this meant; however, my clinical skills were also useful in terms of being able to listen carefully to the parents' accounts and to respond sensitively to them. I also think my clinical skills helped me to understand the parents likely difficulties in opening up to me and allowed me to try and compensate for this by building rapport and being transparent and open with them.

### **Issue in data analysis**

The interview transcripts in the current study were analysed using a thematic analysis approach. This involved identifying patterns (themes) within the data with the aim of developing a synthesised description of participants' experiences (Braun & Clarke, 2006). A central issue was how interpretative to be of the data. Braun and Clarke (2006) make the distinction between two types of thematic analysis, inductive and deductive. An inductive approach is data-driven, aiming to provide a rich description of the whole data set. A deductive approach tends to be more analyst-driven and provides a less detailed description of the data set as a whole, focusing instead on one specific part of the data.

In the current study, I took an inductive approach. However, even within an inductive approach, it is inevitable that analysts will be somewhat influenced by their

own ideas, previous experience and theoretical beliefs and so it is not possible to ever be completely data-driven (Braun & Clarke, 2006). I was faced with the dilemma, as often happens in qualitative analysis, of being data-driven but also of needing to make sense of the data, which involves some form of interpretation. A qualitative researcher can get close to a participant's experience but they cannot gain direct or full access to this, meaning that the researcher takes an active role in making sense of the participants' experience (Smith & Osborn, 2008).

One area that was particularly challenging in terms of interpretation was the issue of whether parents had experienced change in their reflective functioning capacity. As was expected given the complexity of the concept and parents' general difficulties in articulating how they had changed as a result of Minding the Baby, parents did not explicitly report changes in their reflective functioning. However, parents did report increased confidence, wellbeing and for some, better management of personal difficulties. They also spoke of learning to support their baby's development and manage their behaviour, (e.g. dealing with sleep problems and tantrums); with some parents speaking a little more explicitly about an improved understanding of their baby (e.g. learning their baby might cry for no reason and learning that what they do may impact upon their baby). It would have been possible to tentatively conclude from the parents' accounts of changes that their reflective functioning had improved. However, it was hard to know if this was an over-interpretation of the data or not and I concluded that it remained unclear whether the parents' reflective functioning had changed due to the Minding the Baby programme. One advantage of using Braun and Clarke's (2006) approach to thematic analysis is that it is a flexible approach allowing the researcher to make judgments about the degree of interpretation used in the process of analysis.

### **Conclusions**

The design of the current study, as well as how it was conducted, was influenced by my previous experiences of working with parents from difficult

backgrounds. My previous experience had the potential to have both a negative and positive impact on the study and my awareness of this was essential during the research. Consideration of the possible limits in the parents' functioning, socially, emotionally and cognitively was important in terms of how best to tailor the research to these parents. Conversely, consideration of the potential negative impact my preconceptions may have had on the research was also important. The research process in the current study highlights some of the challenges of working with parents experiencing social adversity and ways in which research can be tailored or conducted to account for difficulties the parents might have.

The current study also highlights the importance of obtaining service users' views. These views are an essential part of evaluating whether services are meeting the needs of their users. In terms of parenting programmes such as Minding the Baby, gaining the views of the parents involved can be particularly useful for understanding engagement with the programme and informing the development of the intervention to ensure that it is suited to the parents' needs.

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**Appendix 1**  
**Downs and Black Checklist**

## **Appendix 2**

**Each of two researchers' contributions to the joint project**

The joint project conducted by Lucy Grayton explored the factors which facilitates and hinders building and sustaining relationships with mothers enrolled in MTB and the challenges faced when trying to translate reflective functioning theory into practice, from the perspective of the practitioners delivering the programme. Semi-structured interviews were conducted with 13 practitioners who deliver the programme. Transcripts were analysed using thematic analysis.

The joint product conducted by Phebe Burns explored the factors that facilitated or hindered mothers' engagement in MTB and also whether anything had changed as a result of MTB and what had facilitated or hindered change. These areas were explored from the perspective of parents involved in the MTB programme. Semi-structured interviews were conducted with 16 mothers and three fathers, who were participating in the programme alongside their partners (three of the 16 mothers). The fathers were interviewed jointly with their partners so 16 interviews were conducted in total. Transcripts were analysed using thematic analysis.

**Appendix 3**  
**Ethical Approval**





**Appendix 4**  
**Information Sheet**

***Minding the Baby: The Challenges of Implementing a Reflective Functioning Parenting Programme***

**Participant Information Sheet for Mothers**

You will be given a copy of this information sheet.

We would like to invite you to take part in this study. Before you decide whether you want to take part, it is important for you to know more about the study and what it involves. Please ask us if there is anything you are unclear about or would like more information about.

**What is the purpose of the study?**

This study is being carried out by researchers at UCL (University College London), as part of a larger study of Minding the Baby (MTB) in the UK. We would like to find out about mothers' experiences of MTB, both the positive and the negative. We hope that this study will help us to improve MTB.

**Why have I been invited to take part?**

You have been invited to take part in this study because you are part of Minding the Baby. We hope that around 16-20 mothers will take part in this study.

**What does taking part involve?**

A researcher will contact you to arrange a day to come to your home for an interview. During the interview you will be asked what you think about MTB. The interview will go on for 1 to 2 hours and what you say will be taped to make sure that we do not miss anything. It is possible that we will call you after the interview to ask you some more questions.

**Do I have to take part?**

No. You can decide whether or not to take part in this study, and you can ask to stop the interview at any point, or withdraw from the study after your interview has taken place. Deciding not to take part or withdrawing from the study will not affect the support you get from the MTB service in anyway.

**What are the risks and benefits of taking part?**

Although we hope the interview will be a positive experience, you may find some parts of this interview difficult, as we will talk about things which mean a lot to you (such as your relationship with your child, and becoming a parent). If you find the interview difficult at any point, you can take a break or ask to stop the interview completely. You will not have to answer any questions that you do not want to, and at the end you will be able to talk to the researcher about how you found the interview.

**What will happen to the information I provide?**

The tape of your interview will be listened to and written down; we will then delete the tape. A research team will look at the main things which the mothers said about MTB

and write a report for the NSPCC. This will also be written up as part of a professional university degree, and may be made public in a scientific journal. No personal information about you, like names, addresses or other details that could identify you, will appear in any of these reports. As part of the interview, you will be asked what you think about your MTB workers – none of your answers will be passed onto your workers, or anyone else at the NSPCC, in a way that identifies you (your workers won't be told what you have said about them).

### **Will my taking part in this study be kept confidential?**

Anything that you say during the interview will be kept strictly confidential (which means we will keep it private), unless you tell us something that makes us worry about your safety, the safety of someone else, or the safety of a child. If this happens we may have to break this confidentiality (tell someone what you have told us), but will try to talk to you first.

All information will be collected and stored in accordance with Data Protection Act 1998 (which means it will be kept private). Tapes made during interviews will be password protected and destroyed once they have been written down. Names and any other information which could identify you will be removed from the written versions of the tapes to make sure that you cannot be identified. We will store the written versions of the interview in a secure location for up to 5 years.

### **Complaints**

If you are unhappy about how any part of this study, you can contact the lead researcher, Pasco Fearon (contact details below). You could also speak to any NSPCC member of staff (such as your MTB worker) or please email [comments@nspcc.org.uk](mailto:comments@nspcc.org.uk) or call **020 7825 2775**. You can then ask to speak to Jane Cripps and tell her that the name of the project is: ***Minding the Baby: The Challenges of Implementing a Reflective Functioning Parenting Program***. To find out more about this please go to: [http://www.nspcc.org.uk/help-and-advice/enquiries/frequently-asked-questions\\_wda83770.html#complaint](http://www.nspcc.org.uk/help-and-advice/enquiries/frequently-asked-questions_wda83770.html#complaint).

### **Contacts**

If you would like any further information or have any questions about this study please contact Phebe Burns or Pasco Fearon:

Phebe Burns, Trainee Clinical Psychologist - [phebe.burns.11@ucl.ac.uk](mailto:phebe.burns.11@ucl.ac.uk)

Professor Pasco Fearon, Professor of Clinical Psychology - [p.fearon@ucl.ac.uk](mailto:p.fearon@ucl.ac.uk)

**Research Department of Clinical, Educational and Health Psychology, UCL**

### **Thank-you for considering taking part in this study**

This study has been approved by the UCL Research Ethics Committee (Project ID Number): 4380/001

All data will be collected and stored in accordance with the Data Protection Act 1998.

**Appendix 5**  
**Consent Form**

**Minding the Baby: The Challenges of Implementing a Reflective Functioning  
Parenting Programme**

**Informed Consent Form**

**Please complete this form after you have read the Information Sheet and/or listened to someone tell you about the research.**

Thank you for your interest in taking part in this research. Before you agree to take part, the person organising the research must explain the project to you. If you have any questions about what you have read in the Information Sheet or about what you have been told, please ask the researcher before you to decide whether you would like to take part in the study. You will be given a copy of this Consent Form to keep.

**Participant's Statement**

I: \_\_\_\_\_

- have read what is written above and in the Information Sheet, and I understand what taking part in the study involves
- understand that if I decide that I no longer wish to take part in this study, I can tell the researchers and withdraw immediately.
- agree to the use of my personal information (your name, address etc.) for the purposes of this research study
- understand that this information will be treated as strictly confidential and dealt with under the Data Protection Act 1998 (my information will be kept private and safe).
- agree that the research project (study) named above has been explained to me properly and I agree to take part in this study.
- Understand that what I say will be taped (which will be deleted straight after it is written down) and I agree that this information can be used as part of the study.
- agree to be contacted in the future by UCL researchers if they have more questions after the interview, or if they would like to ask me to take part in some further studies.
- understand that the information I have given will be made public as a report and/or in scientific journals. I understand that confidentiality (privacy) and anonymity (people not being able to work out who I am) will be kept

Signed: \_\_\_\_\_

Date: \_\_\_\_\_

**This study has been approved by the UCL Research Ethics Committee (Project  
ID Number): 4380/001**

**Appendix 6**  
**Interview Schedule**

## Interview Schedule for Mothers

### Background

- How did you find out about MTB?
- When you heard about it, what did you think?
- How long have [insert workers' names] been coming to your house?
- You've been having [insert workers' names] come to your home every week, what has that been like for you?
- What takes place during these visits?
- Would you say MTB has been generally positive or negative, or mixed experience?
  - Prompt: Can you tell me a little more about why it's been [whatever said above]?
- What did other people (your partner/parents/friends) think when you told them about MTB?

### The program and home visits

- What are the things about the program that you like best?
  - Prompt: Can you give me an example of that?
- What are the things about the program that you don't like or find less helpful?
  - Prompt: Can you give me an example of that?
- What kinds of things do you and [insert workers' names] talk about?
- How do you and [insert workers' names] decide what happens (or set goals) in each meeting?
- I know you have home visits every week; do you ever find it hard to keep the appointments?
  - Prompt: What makes it hard?
  - Prompt: What have you done?
- Do you ever wish that [insert workers' names] would stop coming?
- Do you think that you will continue to the end of the program (until your child is 2 years old)?

## Relationship with home visitors

### ***Relationship***

- What are [insert workers' names] like?
- How do you get on with them?
- Can you tell me more about what your relationship is like with them?
- How have things with [insert workers' names] changed over time?
- How do you feel about [insert workers' names] now compared to when you first began working with them?
- How does working with [insert workers' names] differ from working with other professionals, either in the past or now?

### ***Having two workers***

- What has it been like to have two workers?
- Has this made it easier or more difficult for you to work with the team?
- What has it been like to get to know the two different people visiting you?
- What has it been like to get used to two different people visiting you?

### ***Each worker (ask this set of questions for each worker, in turn)***

*Let's think about your workers one at a time;*

- How do you usually feel during home visits with [insert worker's name]?
- How do you feel after [insert worker's name] leaves?
- What do you especially like about seeing [insert worker's name]?
- What do you like less about seeing [insert worker's name]?
- Are there things that make it easy to work with [insert worker's name]?
- Are there things that make it hard to work with [insert worker's name]?

### ***Further thoughts on workers***

- Do you feel understood by [insert workers' names]?
- Do you ever feel judged by [insert workers' names]?
- How much do you feel you can trust them?
- Do you ever wonder what your workers think of you?

### **Change**

- How are you finding it being a mum?
  - What is it like spending time with your baby?
  - Has this changed over time?
  - Has the program helped or has this had anything to do with the program?
  - have there been other things which have made a difference?
- Is there anything that hasn't changed since meeting your workers?
  - Is this something you wanted to (or expected to change)?

### **Closing Comments**

- If you were going to tell others mums about the program what would you say?
- What would you change about the program if you could?
  - Would you change anything about how the home visitors worked with you and your family?
  - Would you like to see more of one thing or less of another
- Is there anything we have not talked about which you think is important?

Prompts such as 'How' and 'In what way' will be used throughout to elicit further details from the mothers.

Specific examples will be elicited in order to obtain rich data.

**Appendix 7**  
**Steps of Analysis**

**Example from initial step of analysis: annotating/coding the transcript of Participant 8 (coding in italics and bold)**

I: Just starting off, how did you find out about MTB

P: because I was in through youth offending team, not that it was my fault but you know things happen and I ended getting sentenced to a year of youth offending and basically I found out I was pregnant while I was doing it and my support worker mentioned it to me and we met up there

I: and when you heard about it from YOT what did you think

P: at first I thought because I found it was to do with NSPCC I was like what and because I got told it was something to do with social worker kind of thing and I was thinking are they trying to trip me up you know sort of thing but once I actually spoke to them and found out what it was about then I thought it was quite a good idea but at first I was a bit worried cos when you hear NSPCC you think you know protecting children so

- 1. Worried at first because NSPCC and SW, thought trying to trip me up***
- 2. Once I actually spoke to them I thought it was a good idea***

I: so you been having them come every week, you still on every week at the moment so what has that been like

P: I think its quite good actually because you can ask them any questions you have about things and even if you don't have anything to ask them its just nice to have someone to come round

- 3. It is good because you can ask them questions you have about things***
- 4. Even if nothing to ask them nice to have someone round***

I: what takes place when they come round

P: they do like development checks or we will go out like we have been to the park while it was nice and sunny to get out and we do like different things quite a lot

- 5. Do development checks***
- 6. Or sometimes go out***
- 7. We do lots of different things***

I: do you stay in as well

P: yeah

I: what happens then

P: we will have a chat and they will ask me anything and like they will do development checks and like basically we just talk like anything I need to know sort of thing

- 8. I can talk to them about anything I need to know***

**Example of second step of analysis: organising the annotations from transcript of Participant 8 into a table of codes**

1. Worried at first because NSPCC and SW, thought trying to trip me up	33. They are professional but not very strict like other professionals, they are quite relaxed
2. Once I actually spoke to them I thought it was a good idea	34. Good to have 2 workers because get a change every week
3. It is good because you can ask them questions you have about things	35. They are both from different backgrounds so you have different opinions about different things you might want to talk about
4. Even if nothing to ask them nice to have someone round	36. Alright to get to know the 2 people because they came together for first few weeks so know them quite well before started coming alone also good because means you don't have to repeat things
5. They do development checks or sometimes we go out	38. Time just flies during visits with W9, talk about all sorts, really like her
7. We do lots of different things	39. It is really relaxed, we have similar personalities so get on really well
8. I can talk to them about anything I need to know	40. Can talk to W9 about pretty much anything and not feel worried about it
9. Positive experience because they have always helped when I have needed something with the council or whatever	41. She is always really happy and down to earth
11. Helped out whenever they can	42. Easy to work with her because she knows me and we have talked so much
12. Nice to talk to someone that you know and they have never been funny or anything	43. She makes you feel comfortable to talk to her about anything
13. I like that it stays the same 2 people so don't have to explain same thing all the time	44. Visits with W10 really good because I talk to her about anything to do with baby
14. I like that it is regular, don't just pop out of nowhere but arrange visits instead	45. Usually feel relieved after visits with W10 because feel like I have done right thing with baby
15. Talk about what baby has been up to recently, any questions I have about baby and about college and what I want to do after, W10 helped me organise college	46. Like that W10 can use her experience with her own kids to give me her opinion on things
18. Set goals in meetings: ask me how I am feeling about stuff and would I like to do this or that and the we decide goals together	47. W10 really easy to get along with, can talk to her about pretty much anything
21. Always been easy to organise their visits and it is a nice thing so I try and fit them in	48. She is also good with information
22. Flexibility of appointments is good because means I don't feel like I can't do things or have to stay in because of MTB coming	49. Feel understood by them

**Example of third step of analysis: clustering the data into tentative themes  
across the transcript for Participant 8**

**What has facilitate/hindered engagement**

**Facilitate**

- once spoke to them, thought a good idea
- knowledgeable/informative
- company
- developmental checks
- go out
- availability
- practical help e.g. with the council
- talk to someone you know
- stays same 2 people so not have to re-explain things
- regular and reliable
- help for me e.g. organise college
- set goals
- flexible
- very chatty, really nice
- professional but not strict
- comfortable/relaxed
- Having 2 means change every week
- different opinions having 2 workers
- came together at first so knew them before starting seeing them separately
- trust them
- reassurance about what I am doing with baby
- Experience of own children
- feel understood
- non-judgemental
- helped in prep for having baby
- like friends
- explain things
- no pressure

**Hinder**

- worried at first because NSPCC and social worker – thought trying to trip me up
- anxious at first

**What changed and how facilitated/hindered**

**Changed**

- knowing more about bonding and weaning

**Not changed**

**Facilitated**

- MTB gave information about bonding and weaning and other stuff so didn't get into it blind

**Hindered**

**Example of later step of analysis: clustering the data into tentative themes across all of the interview transcripts**

*Prevalence of each idea indicated in brackets (e.g. said by interviewee 1,2,3)*

What facilitates/hinders engagement in MTB?

**Available and flexible:**

- Available: whenever need them to talk to; listen to you; come to the house; there for you (1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16)
- Flexible: with visits or telephone contact (4, 5, 6, 7, 8, 12, 13, 14, 16)

**Provide practical help (1, 2, 4, 5, 8, 9, 10, 15, 16)**

**Professional experience and knowledge:**

- Provide advice, guidance and direction from professional backgrounds (1, 2, 3, 4, 5, 6, 8, 9, 10, 11, 12, 13, 14, 15, 16)

**Personal experience and knowledge**

- Provide advice from personal backgrounds e.g. experience with own children (2, 5, 8, 9, 15)

**Program factors and/or personality traits of practioners:**

- Trustworthy (1, 4, 5, 6, 7, 8, 9, 11, 12, 13, 14, 15, 16)
- Open/relaxed/no pressure (1, 2, 6, 7, 8, 9, 12, 13)
- Friendly/funny/have a laugh with them/easy to get along with (1, 2, 4, 5, 6, 7, 8, 11, 12, 14, 15, 16)
- Non-judgmental (1, 2, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16)
- Reliable (7, 8, 9, 11, 12, 15, 16)
- Trusting of mothers to do their own thing, not tell them what to do (1, 2, 5, 6, 7, 10)
- Coming together at start before coming separately is easier for mothers (2, 7, 8, 12, 14)
- Interactive with baby (4, 6, 10, 12, 13, 16)
- Attentive to baby and mothers needs e.g. check baby's development and mother's needs. (1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16)
- Collaborative e.g. set goals together (7, 8, 9, 10, 13, 16)
- Reassurance (1, 6, 8, 9, 11, 12, 13, 14)
- Working with both mother and baby (14, 16)
- Provide company (8, 11, 12, 14)