‘What support would you find helpful?’

The relationship between treatment expectations, therapeutic engagement and clinical outcomes in Parent-Infant Psychotherapy

Abstract

The aim of this study was to investigate the impact of pre-treatment expectations on clinical outcomes and engagement in Parent-Infant Psychotherapy (PIP). Sixty-one mothers who were experiencing mental health difficulties and who were receiving PIP with their young infants participated in the study. A mixed-methodology was used to examine participants’ expectations through transformation content analysis of pre-treatment interviews; recurring themes were classified and quantified. Further statistical analyses explored relationships between the quantified themes of parental expectations and clinical outcomes and engagement in treatment. No significant correlation was found between expectations and engagement. One of the six clinical outcomes significantly correlated with parental expectations. Improved reflective functioning (RF) was predicted by participants describing expectations of wanting to improve their parent-infant relationship through the treatment, and expressing concerns about discussing their past experiences. These two expectations predicted improvements in RF independently and when combined. These results indicate that PIP may be more effective for some mothers than others and that assessing future clients’ expectations before beginning PIP may be beneficial.

Keywords: Parent–Infant Psychotherapy, Attachment-Based Intervention, Early Intervention, Engagement, Expectations.

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The relationship between treatment expectations, therapeutic engagement and Clinical Outcomes in Parent-Infant Psychotherapy

The attachment relationship between a parent and an infant is integral to development. This dynamic bond is not solely for infantile survival, it is necessary for their cognitive, psychological and social development (Sroufe, 2005). However, parental mental health difficulties may impinge on the parent’s capacity to act as a regulator to the infant, often resulting in attachment insecurity and disorganization (Baradon, et al., 2005; Atkinson et al.; 2000). It is therefore imperative to tackle parental mental health issues, in relation to parent-infant attachment, within the first years of an infant’s life (Fraiberg, 1980; Wan & Green, 2009; Atkinson et al., 2000).

Parent-Infant Psychotherapy (PIP) is focused on building and maintaining the relationship between parents and infants. Yet, recent research has begun to highlight that some ‘high- risk’ parents with mental health difficulties can find it difficult to engage in therapy, and that the outcomes of such treatments are mixed (Fonagy, Sleed and Baradon, 2016; Barlow, Bennett, Midgley, Larkin and Wei, 2015). This research aimed to explore whether parents’ treatment expectations impacts their engagement in therapy, and the clinical outcomes of the treatment.

Disruptive Factors to the Parent-Infant Relationship

The quality of attachment between an infant and a parent can affect how a child will form relationships, learn, and regulate their emotions, as well as their cognitive development (Bohlin et al., 2000; Fearon et al., 2010; Waters et al., 2000). There is mounting evidence of the severe long-term effects of disturbed early relationships (Baradon et al., 2005; Fonagy et al., 1994; Glaser, 2000; Tiesl & Cicchetti, 2008; Gunnar & Quevedo, 2007). A multitude of

factors can disrupt a parent's ability to meet their infant's needs. This study primarily focuses on the specific population of parents with mental health difficulties.

Parental mental illness can impact parent-infant attachment to varying degrees (Atkinson et al., 2000; Wan & Green, 2009). Manning and Gregoire (2006) highlighted that parental mental illness can affect the parent-infant relationship both directly (e.g. genetically) and indirectly (e.g. socioeconomic disadvantage), mediated by multiple factors such as; the severity of the illness and a child's exposure to the parent's unpredictable mental states. Wan and Green (2009) reviewed the current evidence on the impact of maternal psychopathology on child-mother attachment, including a meta-analysis by Martins & Gaffan (2000). The review emphasised that most children whose mothers have mental health problems do not develop lasting attachment difficulties. Yet, it can impact the resilience that a child develops in later life. Parents who suffer with more complex mental illness, such as Borderline Personality Disorder (BPD), often have difficulty in regulating their own emotions, so attempts to regulate an infant's emotions can be extremely challenging (Petfield, Startup, Droscher & Cartwright-Hatton, 2015; Macfie, 2009). The evidence is still unclear if this results in long term affects on attachment, but it does suggest that support for these parents and their children can potentially build resilience.

Furthermore, Newman and Stevenson (2005) found that parents who have a mental illness due to their own personal traumas and attachment issues, are more likely to re-enact the parenting styles and disorganised attachment relationships that they experienced with their own children. This highlights an inter-generational link in parenting, trauma and attachment (Downey & Coyne, 1990; Baradon, 2009; Fonagy, Steel, Moran, Steele & Higgitt, 1993). In light of this research, treatment should target parents with mental health difficulties; particularly those whose difficulties have roots in their own difficult attachment experience to

ensure these patterns of parenting are not repeated and that their infants can develop resilience.

Interventions to aid Parent-Infant Attachment; Parent-Infant Psychotherapy

Parent-Infant Psychotherapy (PIP) directly targets the attachment relationship between the parent and infant (Baradon et al.; 2005). The therapy takes place with both the parent and child together, in the same room. PIP aims to help parent's regulatory capacities and to facilitate the formation of secure attachment (Pozzi & Tydeman, 2007). Often this work involves exploring a parent's own childhood and thinking about what they hope their relationship with their own child to look like (Baradon et al. 2005). Woodhead and James (2007) portrayed how improving a parent's ability to mentalize their infant and regulate their own emotions can lead on to increases in the parents' enjoyment of their parenting role.

A recent systematic review by Barlow, Bennett, Midgley, Larkin and Wei (2015), examined eight studies with 846 randomized participants, comparing either PIP with a no-treatment control group (four studies) or comparing PIP with other types of treatment (four studies). The review highlighted that although PIP was a promising model of treatment in terms of improving infant attachment in 'high-risk' families, there was no significant difference in clinical outcomes between PIP and other types of treatment such as Video-Interaction Guidance. Barlow et al., (2015) stated that treatment might have been more effective for specific dyads, such as those where the parent had mental health issues. They suggested this area should be researched more extensively in the future.

More recently, Fonagy, Sleed and Baradon (2016), conducted a randomized controlled trial to examine the efficacy of PIP with mothers who were experiencing mental health difficulties and their babies under a year of age. This study showed that PIP positively impacted mothers' mental health and psychological wellbeing and their representations of

their babies, compared to treatment-as-usual. However, no differential effects were shown over time between the PIP and control groups on three outcome domains: parent-infant interaction, maternal reflective functioning (mentalization) and infant attachment.

These findings highlighted clear improvements in parental wellbeing, but not in the specific relationship between parent and infant, at least for the sample as a whole. However, despite the explicit inclusion and exclusion criteria, the study sample was relatively heterogeneous in relation to the aetiological factors leading to referral for support. Further research is needed to address the question of whether or not there are differential outcomes for different types of parent-infant dyads, particularly in terms of the factors leading to referral and parental expectations of treatment.

This study also found high rates of attrition from treatment (18%), suggesting that there may be a number of factors that impinged on therapeutic engagement. There is a need to further our understanding of how to engage different types of families in treatments and how to facilitate improvements in parent-infant relational functioning in high-risk dyads. One of the key factors that may play a part in predicting therapeutic engagement and outcomes is the expectations that parents have about the support they would like.

Therapeutic Engagement, Expectations of Treatment, and Clinical Outcomes

Therapeutic engagement is viewed as implicitly necessary for progress and positive outcomes in therapy. Schmidt-Neven (2010) stressed that the therapeutic relationship between therapists and their clients is at the heart of treatment, particularly when working with children and parents. Yet, it is essential for the client to be motivated and want to change, which can often be difficult to assess with patients who have on-going complex mental health issues (Stark, Rouse, & Livingston, 1991).

Kazdin, Holland and Crowley's (1997) research on families' experience of barriers-to-treatment, found that many factors influence families to drop out of treatment early. Kazdin, Holland and Crowley, created the barrier-to-treatment model. This model proposes that often families experience multiple barriers-to-treatment, which increase the risk of dropping out. These factors might be both related to a family's demographic or to their expectations of the treatment. Kazdin, Holland and Crowley found a correlation between an increased number of barriers and increased likelihood of a families dropping out of treatment early. This model highlights the importance of considering families' multi-dimensional views of treatment, not just their demographic background.

Nock and Kazdin (2001) define the expectations of treatment as "anticipatory beliefs about procedures, outcomes, therapists, or any other facet of the intervention and its delivery" (p.155). Greenberg, Constantino and Bruce (2006) point out that patient expectations of treatment are undervalued within psychotherapy, despite the vital role that they play in the psychotherapeutic process. Research has begun to explore at a deeper level the impact that expectations of treatment can have on clinical outcomes.

Constantino, Arnkoff, Glass, Ametrano, and Smith (2011) conducted a meta-analytic review of 46 studies with a total of 8,016 participants. This review examined participants' expectations of outcomes from psychotherapy, and the effect these views had on clinical measures of outcomes. They found that there was a correlation between those participants who improved on clinical outcome measures and participants who had held the expectation that there would be a positive change in their lives (Meyer et al., 2002; Joyce, Ogrodniczuk, Piper, & McCallum, 2011; Abouguendia, Joyce, Piper, & Ogrodniczuk, 2004). The strong connection between patient expectations and outcomes of treatment has been consistently corroborated in multiple contexts and with different types of treatment, e.g. Adult Psychotherapy and CBT (Brown et al., 2014; Newman & Fisher, 2010; Price & Anderson,

2012; Thompson-Hollands, Bentley, Gallagher, Boswell, & Barlow, 2014; Tsai, Ogrodniczuk, Söchting, & Mirmiran, 2014; Vîslă, Constantino, Newkirk, Ogrodniczuk, & Söchting, 2016)

Furthermore, Salomonsson and Sandell (2011) examined the predictive and moderating influences on the clinical outcomes of treatment in Mother-Infant Psychotherapy treatment. They found two types of expectations of treatment were predominately held by mothers. They were classified as "Participators" who wanted to take part in a psychoanalytic exploration, or "Abandoned" who expressed feeling forsaken, either because their partner had left them, or because they felt the child competed with their need to be take care of themselves. This study found that "Participators" benefited more from PIP, particularly in improvement of maternal interactive sensitivity, compared to mothers whose ideals were viewed as "Abandoned". Salomonsson and Sandler's results must be considered within the current research, specifically in relation to where mothers view their primary difficulties to lie within the relationship between her and her baby or within herself.

Expectations of treatment appear to have a strong impact on engagement in treatment; they can seriously hinder or promote therapeutic engagement and correlate with positive clinical outcomes of treatment (Costantino, Ametrano and Greenberg; 2012). Therefore, it is important to conduct further research into how expectations of treatment impact engagement and the clinical outcomes in treatment within different types of intervention, such as Parent-Infant Psychotherapy.

Current Study

In light of previous research, which has highlighted that expectations of treatment can influence therapeutic engagement and clinical outcomes of treatment, this study aims to assess whether this is also the case in PIP. The current study is a secondary analysis of data from two randomized controlled trials of PIP with parents who have mental health difficulties.

The research question was: how do expectations of treatment affect therapeutic engagement and clinical outcomes in Parent-Infant Psychotherapy (PIP) for parents with mental health difficulties?

Based upon the literature discussed on treatment expectations and therapeutic engagement, it was hypothesised that participants' expectations would influence participants' engagement in PIP and the clinical outcomes from treatment. It was further hypothesised that those parents who held negative expectations of treatment, or those mothers who expected a type of treatment which is dissimilar to PIP, would be more likely to drop out of treatment prematurely and make no clinically significant changes.

Methodology

Design

This study is a secondary analysis of two randomized control trials of Parent-Infant Psychotherapy. Both studies were longitudinal clinical studies, with participants randomly allocated to either PIP or control groups. Parents with mental health problems and their infants were assessed over a 12-month period. As the two trials had different control conditions, this current study focuses only on the participants allocated to the PIP treatment group. Apart from different control conditions, the same protocol was followed for both studies, facilitating the pooled data for PIP cases. A mixed methodology was used to investigate the relationship between parental expectations, engagement, and clinical outcomes from treatment.

Ethical Considerations

All data used within this study had been anonymised prior to analysis. Moreover, the study research protocol received full ethical approval by the National Health Service Research

Ethics Committee (Reference No. 05-Q0511-47) and was registered on the International Standard Randomized Controlled Trial Number Register (ISRCTN38741417).

Participants

A total of sixty-one participants enrolled in the studies were allocated to the PIP treatment arm. The study took place at four locations across England. These areas are all identified as demographically diverse with high levels of socioeconomic deprivation. PIP was conducted at community children's centers and hospital-based perinatal psychiatric units. Participants were referred to the study by social care and health professionals working within these areas (e.g. health visitors). Once a referral was made the research team conducted home visits to gain informed consent and assess families' eligibility to participate. The description of the total sample is provided in *Table 1*.

[Insert Table 1]

Moreover, participants had to meet a set criterion to take part in the study:

Inclusion Criteria:

1. The parent had been independently identified by a professional as requiring mental health services;
2. The child was less than 12 months of age;
3. Mothers met probable psychiatric case criteria based on the General Health Questionnaire (>4/5); and
4. Mothers met at least one of the following indicators of social exclusion:
    a. Low-income household (eligibility for income support)
    b. Long-term unemployment (>2 years)
    c. Temporary or overcrowded accommodation (more than 2 persons per room)
    d. Unmarried and unpartnered

e. Presence of chronic physical illness or disability
f. Early childhood history of foster or institutional care
g. Social isolation associated with recent relocation
h. Less than 20 years of age
i. Previous diagnosis of non-psychotic psychiatric illness.

Exclusion Criteria:

1. Non-English speaking families
2. Current maternal psychosis
3. Substance-abuse disorders/chronic drug dependence
4. Maternal IQ < 70
5. Infants with any sensory or motor disability that would prevent their participation in a standard developmental assessment (e.g., blindness, hearing impairment, cerebral palsy).

Procedure

Pre-treatment assessments of eligibility for the study took place in local clinics and the participants' homes with the research team. During these assessments, semi-structured pre-treatment interviews we conducted and participants completed a number of clinical measures. These measures were then reassessed after the intervention, at a 12-month follow-up. For those participants who ended treatment prematurely but who remained in the study, outcome measures were still conducted at the 12-month follow-up.

After the initial assessment and randomization, participants allocated to PIP were then invited to begin the treatment. Over a twenty-six week period, participants attended an average of 12 sessions (M= 11.98, SD = 12.66). This research focuses primarily on parents'

expectations of treatment within the pre-treatment interviews and the clinical change in outcomes measured.

Intervention

Treatment was based on the manualised approach of PIP outlined by Baradon et al., (2005). Six experienced clinicians, who had a detailed understanding of the intricacies of PIP, conducted the interventions. The PIP intervention was offered in four locations that covered the geographical areas of the recruitment sites and were therefore local and accessible to the families.

Sessions focused on observing interactions in the room between parent and infant, whilst trying to understand the meaning behind interactions in relation to participants past and current experiences and relationships. Both interactions that support infant development as well as affective and behavioural impingements are addressed, with particular attention being drawn to non-verbal communications (Beebe and Steele 2013). The intervention aims to reduce precocious defensive behaviours in infants, such as avoidance, inhibition and dissociation, which are associated with negative developmental outcomes (Lyons Ruth et al 2013). Additionally, the intervention aims to promote parental mental health, well-being and reflect functioning (Woodhead & James, 2007).

Measures

During pre-treatment interviews participants were asked three open-ended questions were asked to gain insight into participants' expectations of treatment:

1) If you could think of a service that would be helpful to you and your baby, what would it be like? What would really help you?
2) What would you like to change with the help of a support service?

3) Is there anything in particular that you hope not to happen when you have contact with a service? What would you find difficult or unhelpful?

Measures of Engagement

Therapeutic engagement in treatment was assessed and recorded by the clinicians treating each participant. Therapeutic engagement was measured dichotomously at the 12-month follow-up, by asking therapists' whether they felt treatment was completed with a mutually agreed ending, or whether they felt the clients left treatment prematurely. This variable was considered a more clinically valid indicator of engagement than actual number of sessions attended or missed, as the treatment was open-ended. The number of sessions offered by clinicians varied according to the needs of each dyad. For example, one client was offered twenty-six sessions and missed three, whilst another was offered seven sessions and missed three, yet both were viewed to have engaged and completed treatment and had positive clinical outcomes.

Baseline Measures and Outcome Measures

Six measures were used to assess: parental mental health, infantile development and the relationship between parent and baby. These measures were completed with participants prior to treatment, after treatment and at a 12-month follow up.

1) Parenting Stress Inventory Short Form (PSI- SF), was used to examine mothers' levels of parenting stress (Abidin, 1995). This is a 36-item questionnaire that measures parents' levels of stress on a five-point scale, with good internal consistency and validity (Reitman, Currier and Stickle, 2002).
2) The Bayley's Scales of Infant Development, 2nd & 3rd Ed. (BSID-III), assesses infant development, both cognitive and motor development (Bayley, 2006). The BSID-III can be used with infants aged between 1 and 42 months, it has

been found to have strong validity (Hoffman, Marvin, Cooper, & Powell, 2006).

3) The Centre for Epidemiological Studies Depression Scale (CES-D) examines levels of maternal depression and the potential impact of these symptoms (Devins et al., 1988). This 20-item questionnaire yields scale scores as well as a binary measure of likely impairment (cutoff score >16), it has verified psychometric properties (Clark, Mahoney, Clark, and Eriksen, 2002).
4) Emotional Availability Scale (EAS) was used to measure parental sensitivity, structuring, non-intrusiveness, non-hostility, child responsiveness and involvement (Biringen, Robinson, & Emde, 1993; Biringen, Robinson, & Emde, 2000). The EAS has been shown to have good concurrent validity with infant attachment classifications (Ziv, Aviezer, Gini, Sagi, & Koren-Karie, 2000).
5) Maternal Sense of Mastery assessed mothers' sense of mastery over their life (MMS) (Pearlin & Schooler, 1978). This questionnaire asks participants to respond, on a seven-point scale, to questions about their feelings of having control over their life, particularly in relation to their role as a parent.
6) The Parent Development Interview (PDI; Slade, Aber, Bersgi, Berger & Kaplan, 2004) was used to assess Reflective Functioning (RF); a parent's ability to understand their child's behaviours in relation to their intentions and mental states (Fonagy, Steele, Steele, Moran, & Higgitt, 1991). Inter-rater reliability was assessed, it was deemed adequate (ICC = .762).

Data analysis

Mixed-method analysis was conducted. Transformation content analysis, a type of thematic analysis, was used to classify recurring themes within participants pre-treatment

interview, these theme were then quantified. The analysis used was based upon the techniques outlined by Braun and Clarke (2006). Once the themes were quantified the relationship between themes of expectations, engagement in treatment and clinical outcomes of treatment could be explored through multiple analytic tests; Chi-squared Cross tabulation, Pearson's correlation and linear regression.

Thematic analysis enabled in-depth exploration of all the answers to the questions, resulting in a rich understanding of the recurrent themes, whilst quantitative analysis offers insight into the predictive relationship between expectations, engagement and clinical outcomes. The first named author conducted the thematic analysis and the second author, who conducted most of the pre-intervention interviews, carried out credibility checks of the coding throughout.

Results

Thematic Analysis

The in-depth qualitative analysis of the participants' pre-treatment interviews highlighted mothers' varied expectations of treatment. In total, twenty-two themes were deemed relevant and were recorded; a participant could mention more than one theme. From these twenty-two themes, eight superordinate themes were defined (*Figure 1).* A cluster analysis was used to inform the selection of themes, which assessed whether each theme was still representative of the participants' expectations without variance (*Table 2).* The following sections describe each of the final eight superordinate themes.

[Insert Figure 1]

[Insert Table 2]

Superordinate Themes

Clinical Symptoms

Eleven mothers explicitly made reference to how they hoped and expected treatment to help reduce the clinical symptoms of their current mental health difficulties. This theme was defined as mothers describing their expectations of clinical symptoms reducing or improving due to the intervention. For example one mother explicitly stated: “I expect to feel less depressed or not depressed at all”, whilst another spoke about how she hoped to “be able to enjoy the children more if I never get those low patches, those really low patches.”

Parent-Infant Relations

Ten mothers spoke about their expectations and hopes that treatment would have an impact on their relationship with their child. This theme was defined as; mothers making a direct reference to the proposed treatment aiding the relationship between parent and infant. One mother wanted to “have more of a, kind of an emotional relationship with my daughter”. Whilst another spoke about needing to “you know, really concentrating on her and on our relationship.”

Uncertainty

Twelve mothers in their pre-intervention interviews brought up a sense of uncertainty of what PIP entails. This theme was defined by the explicit reference to uncertainty of what they expected to happen in therapy. This included participants who highlighted a vague uncertainty of not knowing what could change or what they expected to change due to therapy. E.g. “I don’t know, as I say this is a first time experience umm...I mean ... I mean I’m just seeing how it goes.”

Coping Strategies

"Just like learning how to cope really and what to do, and wondering really, is it normal you know? Some days I feel like I can't be bothered or I hate this." This theme was coded to include parents making reference to therapy helping them learn coping strategies. Thirteen parents spoke about their expectations that treatment would help them learn some coping strategies, which could help them with the challenges they face as a parent with a mental health illness.

Past

Nine mothers expected to talk about their past experiences during the intervention. These mothers expressed worry and concern about the prospect of discussing their own past. This theme was defined as participants making explicit reference to finding it difficult to discuss past experiences. Participants spoke about their desire to focus on the current situation and relationship with their child instead of talking about their past. "I don't want to sort of think, oh God I've got to talk about my mum again. You know, I think my fear is that it will have negative connotations rather than being a positive experience."

Mistrust in Services

Nineteen parents spoke about their own mistrust of services. In particular mothers spoke about a fear of a breach in confidentiality and the fear of their children being taken into care. These mothers often seemed guarded and discussed how even though they understood the concept of confidentiality they were afraid it would be broken. For example one mother said; "you know like I said, I want whatever I say to be kept private, I don't want it to, you know be spread to other agencies, or anybody like that." Whilst another said; "The only service I would say no to is if they take my son, my children, away from me."

Internal Change

Increasing confidence, improving emotional regulation and having a space to talk about problems, were all classified under the umbrella theme of 'Internal Changes'. Thirty-six parents spoke about how they expected treatment to help improve their internal and emotional world. Twelve mothers discussed how they expected treatment to increase their confidence; "because if I'm happier and I'll be able to be more confident and that will reflect in my parenting, and I think the babies will feel happier if I'm more confident." Whilst some other mothers brought up how they felt treatment could help their general emotional balancing e.g. "Probably how well I balance myself emotionally." Some participants also spoke about how they expected to find talking helpful, by reducing their stress from parenting. 'Yeah I would like to talk to somebody to alleviate my problems and the stress of it all'.

Non-therapeutic interventions

Forty-one mothers spoke about other types of interventions and support from services that they would find helpful. Eleven of those mothers spoke about how they hoped and expected treatment might be able to improve their knowledge of child development and offer them some general parenting advice. The following quote from one mother highlights how concerned some parents were about their ability to parent:

"Just you know how to deal with C, that would be one thing, to know how to look after C properly, how to deal with things that will come up. For instance, am I doing the right thing, picking him up all the time, or is it going to do damage, is it unfair to him."

Fourteen mothers spoke about how they would find some practical support very helpful. These mothers discussed the difficulties of having an infant, with many of them speaking about needing some physical time alone; "Having maybe an evening out or you know, or just some time to myself."

Additionally, this theme includes mothers who spoke about how they hoped treatment would help them to "maybe meet other people that are in the same situation". Sixteen mothers spoke about wanting to gain support from other parents in similar situations. However, it is important to remember that even with this sample, participants held conflicting views with each other about what would be helpful. For example on mother directly opposed to working within a group, "I think being in a big group is something I… I wouldn't be able to do."

Descriptive Statistics of Expectations of Treatment

Participants' expectations of treatment were quantified by using the superordinate themes from the cluster analysis as variables. The descriptive statistical data is portrayed in *Table 3*.

[Insert Table 3]

Association between Expectations and Treatment Engagement

Frequency analysis showed that 50.8% of participants were viewed to have ended treatment prematurely according to the therapist. Pearson's Chi-squared tests were conducted examine whether participants' pre-treatment expectations were related to their engagement in treatment. No significant relationships between any of the eight expectations and engagement were found in Pearson's Chi-Squared tests.

To examine the strength of relationships and whether any or several of the expectations could predict engagement in treatment, a test of logistical regression was run. No individual significant relationships were found between the individual expectations of participants and their engagement in treatment from the therapist's perspective. Furthermore, the model itself was found to be non-significant; Chi-squared= 5.764, p=0.674, df=8, Nagelkerke's R^2 of .120, Wald of criterion, p=0.898.

Association between Expectations and Therapeutic Outcomes

The relationship between participants' expectations and participants' clinical change were explored through correlational analysis and linear regression. Analysis of the data highlighted that the skewness and kurtosis values for all clinical change scores are within an acceptable range to make assumptions of normality, ranging from -.948 to .414. Examination of the QQ plots also demonstrated that assumptions of normality were justified. A positive correlation was found between improved Reflective Functioning and participants expectation of treatment to help improve the relationship between parent and infant, r (46)= 0.417, p=0.004. Furthermore, a positive correlation was found between improved Reflective Functioning and the expectation and fear of discussing past experiences, r (46)=. 328, p= 0.004. The correlations between expectations and change scores on all other outcome measures were not statistically significant see *Table 4.*

[Insert Table 4]

Linear regression was conducted based on the information gained from correlations. This test was run to assess if participants' expectations of improving the parent-infant relationship and their expectation of not wishing to discuss past experiences, predicts positive change in Reflective Functioning.

Through simple linear regression it was highlighted that participants' who held the expectation of treatment improving the parent infant relationship were predicted to have a positive increase in Reflective Functioning, (F (1,44) = 9.239, p <0.05) with an R^2 .174 and VIF = 1.000).

Similarly, participants who held the expectation of not wishing to speak about past experiences were also predicted to have an improved Reflective Functioning, ($F(1,44) = 5.292$, $p<0.05$), with an R^2 of .107 and VIF= 1.000).

Multiple regression analysis was then conducted to test if, within a model, the combined effect of the two expectations (wanting to improve the parent-infant relationship and not wishing to speak about the past) could significantly predict improvements in Reflective Functioning. The results of the regression indicated the two predictors significantly explained 24.4% of the variance ($F(2, 44)=6.937$, $p<0.05$), *Table 5.* Post-hoc power analysis indicated that the power to detect obtained effects at $\alpha = 0.05$ was .99 for the regression model and VIF=1.025.

[Insert Table 5]

Discussion

This study offers a new perspective into understanding the impact that parental expectations can have on engagement in Parent-Infant Psychotherapy (PIP) and the clinical outcomes of treatment. Detailed qualitative analysis highlighted the varied and individualised expectations that participants held. Although, contrary to hypotheses, no significant relationship was found between parents' expectations and their engagement in PIP, yet some notable findings can be drawn from this study. The most noteworthy being that improved Reflective Functioning was predicted by participants who held the expectations of wanting to improve their parent-infant relationship through the treatment, but who also expressed concerns about discussing their past experiences.

Participant's Expectations of Treatment

Qualitative analysis highlighted that participants expressed an array of positive expectations for the outcomes of treatment, such as hoping to learn coping strategies,

expecting treatment to improve confidence and emotional regulation. Despite these hopes of treatment being positive and change focused, these views did not predict engagement in the intervention. This stresses the importance of exploring other factors or barriers that may have hindered their engagement (Kazdin, Holland and Crowley,1997).

Unlike those mothers with clear expectations of positive clinical improvements within PIP, twelve mothers spoke about their uncertainty. This uncertainty appeared individual to the client, but critically one must consider that at the point of the pre-intervention interviews participants were unaware which treatment they would be receiving as part of the RCT, PIP or the control condition. They were told that both treatments could be beneficial, but research was needed to understand more about which treatment would be more efficacious for different families. Moreover, most participants were uncertain about what PIP entailed. One must think about a client's ability to engage in the unknown, as well as a potential mismatch between the expected and the experienced.

Disparity between the expected and experienced was brought to light by those participants who stated that they did not wish to discuss their own past experiences, which where relevant, can be a core element of PIP. Baradon et al., (2005) discussed the importance of the clinician helping the parent to reflect on their own experiences or traumas as a child, together with their relationships with their parents, when these seem to impinge on their own parenting of their infant. However, there was no significant relationship between participants who did not wish to discuss their past experiences and attrition, indicating that even participants holding potentially negative expectations of treatment will not necessarily disengage. This finding highlights that other factors may have played a role in keeping some of these mothers in treatment, e.g. the therapeutic alliance may have be strong enough to explore these difficult topics (Schmidt-Neven, 2010). However, within this study therapeutic

alliance was not assessed therefore one cannot draw any conclusions on its role in engagement.

Notably, half of the participants spoke about wanting something different to, or in addition to Parent Infant Psychotherapy. For instance, some mothers spoke about wanting to learn more about child development, whilst others spoke about wanting to meet other parents in similar situations. However, no correlation was found between mothers who held these expectations and disengagement from treatment. These findings suggest that participants' expectations may not be the only influencing factor or barrier-to-treatment.

The qualitative exploration of participants' pre-treatment interviews has given a detailed insight into the diverse and multi-faceted expectations that participants held. It is evident that despite holding positive and some precautious views of PIP prior to the intervention, these expectations did not impact engagement. By accepting that in isolation expectations did not predict or correlate with attrition rates, one can begin to explore the 'multiple barriers-to-treatment' that each individual participant may experience.

Kazdin, Holland and Crowley's (1997) study offers further insight into explaining why the hypotheses in the current study were rejected. Their research explored the multiple barriers that participants can face in engaging in treatment. They emphasise that clients will not just hold expectations of a treatment in isolation, their expectations will relate to; families' demographics, families' preconceived notions/scripts around mental health services and changes in circumstances. Kazdin, Holland and Crowley's (1997) BTPS scale measures how multiple barriers may impact families' engagement with mental health services. Critically, the current study did not use this scale to assess the other potential barriers-to-treatment that participants may have experience. Therefore, it is possible that the non-significant findings of

this study are due to a narrow view of participants' expectations of treatment, as they did not include other impacting factors such as changes in families' circumstances.

Prediction of Clinical Change

This study has highlighted that some noteworthy links that can be made between expectations and clinical change in parents Reflective Functioning. Participants who held the expectation that treatment would improve their relationship with their infant, who also expressed their concern about speaking about past experiences, were more likely to have improved Reflective Functioning after the intervention. This finding offers a new insight into the efficacy of PIP, particularly as the variables uniquely predict improved Reflective Functioning, as well as predicting improvements together within a regression model.

These findings may feel counter-intuitive as one may hypothesise that parents who are unwilling to discuss their past experience would disengage from a treatment which openly discusses adult attachment experiences and be less likely to show change in Reflective Functioning. However, the findings draw our attention to thinking about why might some parents not wish to discuss their past experiences? One tentative hypothesis may be that these parents have gone through trauma, difficult past experiences, or on-going relational trauma, which they currently do not feel willing to explore. However, research by Steele, Steele and Murphy (2009) highlighted that by using the Adult Attachment Interview (AAI) in clinical treatment, they were able to understand the trauma and relational difficulties that parents were going through, which enabled the clinicians to explore these specific traumas during PIP.

A parent's ability to articulate their concern about discussing their difficult past highlights their capacity to reflect. Therefore, it is plausible that if a parent was able to engage and discuss these experiences, despite their expectations of finding it hard to talk about their past, they would be able to develop their reflective functioning. Moreover, these parents have

expressed their desire to improve their relationship with their in child. One could hypothesise that they wish to protect their relationship with their child from their difficult past experiences, to attempt to reduce inter-generational links (Downey & Coyne, 1990).

Stern (2014) stressed the importance of a parent's ability to develop reflective functioning within PIP, as this change can have a dramatic impact on the relationship between a parent and their baby. A traumatized parent with low reflective capacity often misattributes or misinterprets their child's cues and behaviours (Slade et al., 2005). Berthelot et al., (2015) highlighted the link between unresolved parental trauma and negative impact on infant attachment. In particular they linked disorganized attachment to a poor mentalizing and reflective capacity in parents who experienced trauma. Yet, working on this within PIP can led to improvements in parents' reflective functioning (Stern, 2014).

In summary, this finding highlights that those parents who are wishing to improve their relationship with their infant, who have also experienced difficulties past experiences, may benefit greatly from receiving PIP.

Limitations

One specific limitation of this study is that only the therapist's perspective was taken into account in assessing if participants' dropped out of treatment prematurely. This restricts the ability to understand participants' reasoning for dropping out of treatment. Moreover, it creates a one-sided perspective on participants' engagement. It is particularly important to consider this when thinking about how this study measured participants' expectations for treatment. As the study focused on participants' expectations, it seems appropriate that their reasoning for terminating treatment is also assessed. By acknowledging this limitation it highlights the potential for future research to ensure that participants' perspective on why they terminated treatment is listened to and explored.

Furthermore, this study only examined one potential 'barrier-to-treatment', participants' expectations of treatment. Kazdin, Holland and Crowley (1997) stressed the importance of assessing multiple barriers-to-treatment e.g. practical barriers. However, this study was conducted as a secondary piece of research. Therefore, one can only retrospectively reflect on how other measures could have been used to assess other potential barriers-to-treatment, such as the BTPS scale created by Kazdin, Holland and Crowley (1997). Although this study did not include the BTPS this study has strength in its bottom-up and subjective qualitative approach, offering a detailed insight into patient expectations of treatment which Greenberg, Constantino and Bruce (2006) stress are undervalued within psychotherapy.

Clinical Implications

It is integral to consider how the findings from this study can help to inform clinical practice. Costantino, Ametrano and Greenberg (2011) discussed the best ways to clinically aid and manage treatment expectations. They felt that by assessing and discussing participants' expectations of treatment it gave more understanding and directionality to the intervention. Moreover, it led to clinicians being able to negotiate and offer psycho-education to the clients prior to beginning an intensive treatment like PIP.

Although no correlation was found between expectations and engagement within this study, 50.8% of participants did drop out of treatment prematurely in the eyes of the therapist. Therefore one must consider the individual perspectives that each parent holds and how this will impact their engagement. By ensuring that clinicians explore the potential barriers-to-treatment or misguided expectations that a client may hold, they will be able to help the client be prepared for PIP. This study proposes that a tool or questionnaire is created to help clinicians have specific conversations with clients before beginning PIP. This tool or questionnaire could potentially help the clinician become more aware of potential barriers, or highlight if the client holds expectations of treatment that are indicative of clinical change. In

particular it could explore clients' views about discussing their past experiences and desires to improve their relationship with their infant, which as the finding from this study suggest, are often indicative of improvements in Reflective Functioning.

Conclusions

This study has emphasised the importance of listening to the perspectives and expectations of treatment that clients hold. Although, the study did not highlight a relationship specifically between expectations and engagement, the findings have shown that expectations can predict a clients' likelihood of clinically significant improvements in Reflective Functioning, which in turn may have multiple clinical implications.

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Table 1. Demographics of Participants

Factor	Total Sample (%)	Frequency	*M.*	*SD*

Mother's Age				
n	100%	61	30.74	5.58
Child's Age (*Months*)				
N	100%		4.29	3.24
Ethnicity				
White British	62%	38		
Black	15%	9		
Asian	13%	8		
Mixed race	7%	4		
Arabic/Middle Eastern	3%	2		
Cohabitating/Partnered				
Yes	64%	39		
No	36%	22		
Low-income Household				
Yes	57%	35		
No	43%	26		
Predisposing Mental Health Difficulties				
Yes	67%	41		
No	33%	20		
First Child				
Yes	62%	38		
No	38%	23		

Tables

Table 2. Total Variance Explained by Cluster Analysis of Superordinate Themes

	Initial Eigenvalues			Extraction Sums of Squared Loadings		
Themes	Total	% of Variance	Cumulative %	Total	% of Variance	Cumulative %
Clinical Symptoms	1.697	21.219	21.219	1.697	21.219	21.219
Improve Parent-Infant Relationships	1.351	16.884	38.102	1.351	16.884	38.102
Learn Coping Strategies	1.253	15.666	53.769	1.253	15.666	53.769
Uncertainty	.977	12.213	65.982			
Discussing Past Challenges	.826	10.322	76.304			
Mistrust of Services	.797	9.962	86.266			
Internal Change	.600	7.496	93.762			
Non-Therapeutic Treatment	.499	6.238	100.000			

Table 3. Frequencies of Themes of Expectations of Treatment.

Expectations of Treatment (*N*= 61)	Frequency	Percentage
Clinical Symptoms	11	18.0%
Improve Parent-Infant Relationship	10	16.4%
Uncertainty	12	19.7%
Learn Coping Strategies	13	21.3%
Discussing Past Challenges	9	14.8%
Mistrust of Service	19	31.1%
Internal Change	36	59.0%
Non-therapeutic treatment	31	50.8%

*Table 4, Correlations between Clinical Change, Outcome Measures * Themes of Expectations*

		Outcome Measures					
Expectations of Treatment		Bayley-Change (*N*=41)	RF Change (*N*=46)	EAS Change (*N*=34)	CESD Change (*N*=38)	Maternal Sense of Mastery Change (*N*=37)	PSI Change (*N*=38)
Clinical Symptoms	*Pearson Corr.*	.905	.192	.127	.282	-.254	-.007
	Sig.	.019	.200	.473	.086	.129	.967
Improve Parent-Infant Relationship	*Pearson Corr.*	.218	.417*	.145	.103	-.089	.082
	Sig.	.170	.004	.415	.537	.602	.623
Uncertainty	*Pearson Corr.*	.024	.111	-.172	.038	-.091	.023
	Sig.	.881	.462	.330	.820	.594	.890

Learn Coping Strategies	*Pearson Corr.*	.047	-.130	-.040	-.160	.317	.243
		.771	.388	.824	.337	056	.141
Discussing Challenges						143	-.042
						399	.803
Mistrust of Services						002	.114
						092	.495
Internal Ch	*Pearson Corr.*	.292	.241	.088	.119	-.213	-.021
	Sig.	.064	.107	.620	.476	.206	.902
Non-therapeutic treatment	*Pearson Corr.*	-.069	-.138	.196	-.035	-.135	-.108
	Sig.	.667	.362	.266	.833	.424	.519

Table 5. Summary of Multiple Regression Analysis for Variables Predicting RF Change

	b	*SE. b*	*df*	*t*	*Sig.*	R^2
Model			2		.002	.244
Improve Parent-Infant Relationships	1.418	.374	1	2.787	.008	
Discussing Past Challenges	1.018	.269	1	2.001	.052	

*. Correlation is significant at p= 0.05 (2-tailed).