

A Journey to the Heart of Contemporary Parent-Infant Psychotherapy Practice: An Interpretative Phenomenological Study

Vivien Sabel*

Integrative Relational Psychotherapist, Clinical Supervisor, Leeds Beckett University, United Kingdom

***Corresponding Author:** Vivien Sabel, Integrative Relational Psychotherapist, Clinical Supervisor, Leeds Beckett University, United Kingdom.

Received: August 02, 2017; **Published:** September 04, 2017

Abstract

Whilst the nature of infant mental health has long been regarded as significant, it is only in more recent years the phenomenon of Parent-Infant Psychotherapy has developed, is receiving attention, and is in receipt of significant financial input and governmental support. This qualitative research sought through investigation to journey to the heart of contemporary Parent-Infant Psychotherapy (PIP) and in doing so uncover current practice in PIP from the perspective of those working in the field of PIP. Semi-structured interviews with four PIP Clinicians were conducted via online face-to-face interviews and the research was evaluated using Interpretative Phenomenological Analysis (IPA). Five superordinate themes were identified 1) Preventative work seen as key to PIP 2) The type of model of practice is variable, leaning toward an integrative model with relational, ethical practice is seen as paramount 3) Compassionate and non-judgmental practice is deemed essential 4) Observational skills from all involved in infant, maternal and paternal healthcare are seen as vital 5) Individual parental attunement seen as key to good practice. Twelve subordinate themes were identified they are further noted and briefly explored. Parent-Infant Psychotherapy has been defined as clinical work undertaken by qualified clinicians with women (and in more recent years men) during and post pregnancy: mothers and their infants, parents and their infants, and fathers and their infants in order to provide support to achieve an optimal relationship between primary caregiver(s) and infant to provide a solid emotional foundation for the future mental health of the infant. The clinicians involved in the study are highly qualified in the fields of psychotherapy, psychology, and infant mental health. Some of the participants involved have completed their own research in the field and others are involved in writing substantially about their findings. Some are involved in teaching and sharing their findings with both clinicians and families. The findings demonstrate the significance of the experience of working in PIP and all concerned recognise the importance of such early clinical work. The findings also identify potential discourse with regard to contemporary training, service provision and practice. These findings deliberate propositions for clinical practice and may support the field of PIP to find the courage to revisit all areas of PIP training and practice in support of all families PIP clinicians are honoured to serve. They further support existing research, but also may provide a framework for a contemporary and new paradigm of a 'right-brain to right-brain' embodied therapeutic model in the field of PIP. This foundational study will provide further opportunities for additional research.

Keywords: *Infant; Parent; Mother; Father; Primary Caregiver; Parent-Infant Psychotherapy; Psychotherapist; Clinician; PIP; PIP Training; Training; Paradigm; Early Years; Infant Mental Health; Mental Health; Perinatal; Postnatal; Antenatal; Maternal; Paternal; Practice; Attunement; Mirroring; Non-Verbal Communication; Non-Judgmental; Compassion; Observation; Therapeutic; Clinical; Familial; Attachment; Self-Care; Equity; Embody; Embodied; Relational and Integrative*

Abbreviations

PIP: Parent-Infant Psychotherapy; IMH: Infant Mental Health; APPG: All Party Parliamentary Group; LSE: London School of Economics; NICE: National Institute for Health and Care Excellence; UKCP: United Kingdom Council for Psychotherapy; BACP: British Association for Counselling and Psychotherapy; IPA: Interpretative Phenomenological Analysis; PND: Postnatal Depression; PPD: Postpartum Depression; PPP: Postpartum Psychosis; PTSD: Post-Traumatic Stress Disorder; NICE: National Institute for Health and Care Excellence; LSE: London School of Economics; BSL: British Sign Language

Chapter 1

Introduction

In 2014 London School of Economics (LSE) and Centre for Mental Health produced a collaborative report that states, £8.1 billion each and every year are the costs associated with perinatal mental health in the UK alone.

The Costs of Perinatal Mental Health Problems UK

Key Findings

Perinatal depression, anxiety and psychosis together carry a total long-term cost to society of about £8.1 billion for each one-year cohort of births in the UK.
Nearly three-quarters (72%) of this cost relates to adverse impacts on the child rather than the mother.
Over a fifth of total costs (£1.7 billion) are borne by the public sector, with the bulk of these falling on the NHS and social services (£1.2 billion).
Other costs include loss of earnings/impact on someone’s ability to work and quality of life effects.
The average cost to society of one case of perinatal depression is around £74,000, of which £23,000 relates to the mother and £51,000 relates to impact upon the child.
Perinatal anxiety (when it exists alone and is not co-morbid with depression) costs about £35,000 per case, of which £21,000 relates to the mother and £14,000 to the child.
Perinatal psychosis costs around £53,000 per case, but this is almost certainly a substantial under-estimate because of lack of evidence about the impact on the child; costs relating to the mother are about £47,000 per case, roughly double the equivalent costs for depression and anxiety.

Table 1: *Designed from data in Bauer et al (2014, p.4) London School of Economics (LSE) and Centre For Mental Health.*

“NICE and other organisations involved with the treatment of perinatal and postnatal mental health provide clear strategies but current provision can be described at best as patchy” ([1] p.5). The Everyone’s Business Campaign suggests that UK-wide national specialist perinatal mental health services are accessible to all women and that these meet quality benchmarks [2].

Every infant in the UK ought to have the greatest possible beginning to life. Perinatal mental health services should be available to support in managing this critical period for ‘m’other and infant. “This period of life is crucial to increase children’s life chances” ([3], p.5).

As a Psychotherapist my work includes managing with clients and patients their experiences: a tragic childhood, an anxious father, a depressed mother, a troubled child and parents who have difficulties in connecting with their babies. These matters fuel in me a desire to know more about a psychotherapy practice that aims to support infants to secure an optimal attachment relationship.

Who are the Psychotherapists working in PIP? What can they tell me about their work in this relatively new area of psychotherapy? My aim is to journey to the centre of this field and share my findings. “This research predisposes to a qualitative interpretative study accomplished through IPA analysis of data gathered from four semi-structured interviews with current PIP Clinicians” [4].

Relationship to PiP

“As a registered and accredited (UKCP, BACP) Psychotherapist my general interest lies in the mind of human experience and phenomenology of human nature. Specifically of interest, are early years, infant and parent mental health and Parent Infant Psychotherapy (PIP). This curiosity evolved as a result of undertaking psychotherapy work with children and has been cultivated, since journeying into motherhood” [4].

Facts and Figures

Table 2 estimates 284,890 women are affected by perinatal illness in England each year. This figure does not consider paternal mental health. Nor does it include those who do not seek assistance during or post birth. “A high proportion of cases of mental ill health during the perinatal period go undetected” ([1], p.27).

Estimated number of women affected by Perinatal Mental Illness in England each year		
Numbers affected	Type of Mental Health	Symptoms/Descriptors
1,380 2/1000 Maternities	Postpartum Psychosis	Serious. Occurs usually shortly after birth. Symptoms include hallucinations, paranoia, delusions and confusion
1,380 2/1000 Maternities	Serious, Chronic Mental Illness	Chronic e.g. Schizophrenia and Bipolar. Likely to be occur in the perinatal period or experience a reoccurrence and/or deterioration in mental health during or post pregnancy
20,640 30/1000 Maternities	Severe Depression	Serious and persistent. Symptoms likely to affect functionality and included insomnia, irritability, loss of interest, hopelessness etc.
20,640 30/1000 Maternities	Post-Traumatic Stress Disorder (PTSD)	Anxiety Disorder caused by extreme events. May be experienced as frightening, anxiety may increase with shifts in mood and capacity. May experience flashbacks and intrusive thinking
86,020 100-150/1000 Maternities	Mild-Moderate Depressive Illness and Anxiety States	Symptoms include fatigue and persistent low mood/sadness, disinterest and changes in appetite. May have an anxiety constituent
154,830 150-300/1000 Maternities	Adjustment Disorders and Stress-related Mental Health	May not significantly impair function but can be experienced as a result of changes and adjustment difficulties in the pregnancy or perinatal period

Table 2: NB There may be some women who experience more than one of these conditions. Adapted from source: Estimated using prevalence figures in guidance produced by the Joint Commissioning Panel for Mental Health in 2012 and ONS data on live births in England in 2011.

Clinical Positioning

The orientation of my training has veered in what may be depicted as divergent routes: initially training in a psychoanalytic/psychodynamic model and subsequently in an integrative relationally-centred model [4].

“I would situate myself as a relational psychotherapist with a significant interest in the felt sense of the unconscious and an embodied sense of the world of the non-verbal. This embodiment, to which I refer, comes from my own childhood. I was raised by a hearing father and a Deaf, non-signing mother. This has gifted me with an innate sense of non-verbal acuity, which has developed further through our “contact” ([5], p.2) and communication” [4]. It was refined further through my training as a British Sign language (BSL) Interpreter.

¹‘M’ other’ relates to the mother, i.e. father, primary caregiver, caregiver etc.

²Registration and accreditation with UKCP & BACP are UK registration bodies.

In my relationally-centred practice, I ‘watch, wait and wonder’ [6] seeking to observe the emergent in the therapeutic space; pondering upon the feelings evoked whilst ‘empathically dwelling’ ([7], p.78) in the relationship. For further consideration, are the “intersubjective” ([8], p. 22) and what may appear as figural in the presentation. Considered observation of the therapeutic relationship is crucial to my practice; where I see “the therapy space as a microcosm of the person’s world and habitual ways of being” ([9], p. 17).

I have highlighted my clinical position, as traditionally PIP is psychoanalytic. I am curious as to how other PIP clinicians operate in their PIP Practice: will they or won’t they be psychoanalytic in practice?

Summary

It is fair to note my interest in PIP is four-fold 1) I have a personal interest in the field of maternal mental health as a result of my clinical work in PIP, my research and, my embodied experiences 2) These intimate experiences (see the reflexivity and transparency section) have sustained and supported me to acknowledge the importance and significance of nation-wide accessible PIP services. 3) There is a paucity of knowledge in relation to contemporary PIP this in itself is relevant to further research. One thematic study in relation to the effectiveness of PIP (Kennedy 2007) and one further quantitative study by [10] have been accessed. 4) There is a recognised part of me that feels the above may influence the writing of this paper, with this in mind my aim has been to commit to taking an open stance, viewing it through a reflexive lens [11].

Dissertation Synopsis

Chapter One provides information in relation to facts and figures, clinical positioning, and relationship to PIP. Chapter Two presents the Literature analysed, research aims and rationale. Chapter Three encapsulates the method, sampling, a critique of methods, sample size, ethical matters, and a section dedicated to reflexivity and transparency (for an in depth perspective). Chapter Four delineates the participant data, analysis, superordinate and subordinate themes. Chapter Five outlines the discussion from the data analysis. Chapter Six demarcates the conclusions drawn from the research.

Chapter 2

Literature Review

Introduction

With a topic as specific and contemporary as PIP I considered the literature review in a methodical way by addressing the constituent parts of my specific research question [12] in an attempt to provide an all-encompassing overview of PIP.

Literature Analysis Overview

The aim was to review literature that incorporated all elements of PIP with specific consideration of the following:

Definition of PIP
Traditional PIP
Paternal Mental Health
Conceptions of PIP
The ‘Mother’ of PIP
Early PIP Work
Access To PIP
Key Clinicians in PIP
Neuroscience and Environment

Table 3

I analysed literature both electronically and through a hard copy search trying to assess any prospective gaps. Through this search the contemporaneous nature of the heart of PIP was difficult to find.

Strategic Database Searches
Leeds Beckett University Library
Scarborough Psychotherapy Training Institute Library
Infant Mental Health Journals
ResearchGate
PSYCHArticles
PSYCHBooks
UKCP's The Psychotherapist
BACP Counselling & Research Journals
Google Scholar

Table 4

In the literature search it emerged that there are no IPA papers specifically covering contemporary UK PIP Practice. Using Google Scholar (December 2015, March 2016, June 2016), and the search *“IPA research into parent-infant practice”* suggested on average 339 searches encompassing books, citations and academic papers covering various topics. None of which were directly related to the practice of contemporary PIP. 5,360 searches emerged using the search *“Qualitative research into parent-infant psychotherapy”*. This highlighted citations, books and papers, which covered interesting literature not directly related to contemporary PIP. A further search using *“Quantitative research into parent-infant psychotherapy”* supported the discovery of national and international parent infant psychotherapy journals, where it identified 19,300 were books (many of which could be seen in the previous searches), information regarding parent infant psychotherapy training UK professed to locate 266,000, many of these were international. A Google map search (May 2016) which proposed *“UK Parent Infant Psychotherapists”* displayed five UK organisations. It delineated 3,629 books.

In critiquing this, the depth of the searches and the time-required to complete an extensive search is significant. In addition, the recognition that there is a dearth of knowledge in relation to contemporary PIP practice is to be posited.

Reaching the Parents

Pregnancy, birth and the initial two years can be difficult for all mothers and fathers, however at this time it is also possible to facilitate significant transformation. Parents during this period are particularly receptive to assistance with their infants. The first two years in the life of an infant are deemed as a ‘critical window’, that may provide an opportunity to influence change (The 1001 Critical Days Cross-Party Manifesto, 2013) [3]. This said promoting wellness in infants must consider inclusivity. PIP needs to contemplate further, differences in culture, religion and class [13]. Moreover, parents and infants do not live in isolation, but a wider context and in communities where familial, socioeconomic, cultural and religious questions must be respected

Definition of PIP

Barlow, *et al.* ([10], p.10) suggest, “Parent-infant psychotherapy...involves a parent-infant psychotherapist working...with individual parent-infant dyads [in various] settings, to address a wide range of problems that can arise during the antenatal and postnatal periods.” “This said, it is important to consider that reaching all parents who may need to access parent/child mental health services and the development of manageable, accessible, inclusive services may be more complex” [4]. “Parents are individuals with needs of their own...parents are entitled to help and consideration in their own right...Their parenting capacity may be limited...by poverty, racism, poor housing or unemployment or by personal...problems, sensory or physical disability...” ([14], p. 9).

PIP aims to improve the parent-infant relationship and promotes attachment “by targeting the mother’s view of her infant, which may be affected by her own experiences, and linking them to her current relationship to her child, in order to improve the parent-infant relationship directly” ([10], p.14). Moreover, in an age where “social and international mobility has increased” ([15,16], p.13) parents who have left their homeland may feel less connected to their communities, environment, culture and family. They may experience parenting as isolating and these matters are likely to influence upon parents significantly. Brown and Harris [17] suggest that parents who encounter insufficient support from their network are more likely to experience postnatal depression.

PIP provides an opportunity to observe the “interpersonal communion” between parent and infant ([18], p.148). Early research into infant mental health has emphasized the importance of the mother in regulating the infant [19-23]. However, in consideration of the relationship between the parent-infant it’s vital to observe, “... a woman experiences a unique form of *double identification*... [where she] identifies with her own mother *and* fetus...the reemergence of the relationship to her own mother is a very intense process. [it may transpire]...in a *rapprochement* to her mother” ([24], p.15). As a result, Stern’s [25,26] concept of the “motherhood constellation” must be considered. Moreover, PIP clinician’s are often at the receiving end of transference and projections, and therefore self-care in practice is paramount.

Traditional Psychoanalytic PIP

The traditional approach to PIP has been purely psychoanalytic. Baradon., *et al.* ([15], p.32-33) suggest, “...*formal training and experience* necessary for the practice of PIP in the following disciplines 1) Psychoanalytic clinical practice 2) Infancy and early childhood development 3) Observation skills and 4) Adult mental disturbance”.

To reach the heart of the work with the mother, infant and the parent-infant relationship, consideration of the mother’s attachment model, “internal working model” [27], capacity of “reflective functioning” [28] and her relationship with her own mother (and father) does require the clinician’s understanding and interpretation. For further consideration is Schore’s [29-35] work around “affect regulation”. A keen awareness of transference, projection and projective identification matters needs to be further considered. If this is out of awareness there is a likelihood of psychotherapeutic wounding. Therefore a sensitive and attuned approach seems essential in PIP.

Paternal Mental Health

For further deliberation are findings in a report published January 2016 by BJOG, an international Journal of Obstetrics and Gynaecology needs contemplation, “If depression known as parental depression, is diagnosed in either or both the mother and the father there is an increased risk of preterm birth.” It also highlighted new depression in fathers was associated with a 38% increased risk of very preterm birth. Paternal wellness seems paramount to the wellness of the ‘m’other and may support a decrease in preterm birth.

Furthermore, “White (2007) Madsen and Juhk (2007) identified that better methods for identifying men with postnatal depression need to be developed. Maternal postnatal depression is a strong predictor of paternal postnatal depression, and is an increased risk if the father is unemployed and there are relationship problems” Bria., *et al.* [36] (The Royal College of Midwives 2011 p.6).

Conceptions of PIP

The idea of infant mental health and the significance of the mother-infant relationship have been around for some time. The seedlings of these whole concepts were planted some time before by theorists such as many of the attachment clinical community and those connected to object relations.

Specifically, “the work of Bion [37,38], and the concept of the ‘container/contained’ and Winnicott’s [39-43] theories in relation the ‘good enough mother’ and ‘holding’ are hypotheses that place the role of mother at the forefront in the developmental curve of the infant” [4].

The emphasis placed on infant mental health is comparatively recent. Boukydis [44-47] suggests, “Infant mental health is a relatively new and important field that has, as its core, practices involved with nurturing the parent-infant attachment relationship” [18,48,49]. Boukydis ([44] p.1) further states, “One basic assumption of infant mental health practice is that to the extent mothers are well supported and emotionally healthy, their infants will receive the essential nurturing and emotional sustenance they need for healthy development.” In order to encourage emotional nourishment in the infant, the emphasis is placed upon supporting the ‘m’other.

The ‘Mother’ of PIP

“The ‘mother’ or first person to reference Infant Parent Psychotherapy was Selma Fraiberg” [4]. Lieberman., *et al.* ([50], p. 472) reference Fraiberg’s [51,52] account “Infant–parent psychotherapy aims at protecting infant–toddler mental health by aligning the parents’ perceptions and resulting caregiving behaviors more closely with the baby’s developmental and individual needs within the cultural, socioeconomic, and interpersonal context of the family.” This model encapsulates the wider environment but it does however hold a timbre I feel uncomfortable with. The “...aligning the parents’ perceptions...” has a robotic quality and it lacks a relational warmth. “Interest, respect, empathy and a lack of judgment are necessary to help the patient build up trust in her and their work together” Baradon ([15], p.33).

Early PIP Work Table

Early PIP Clinicians	Date	Type of Practice
Klein	1920’s onwards	Investigation and observation of infants. Psychoanalytic perspectives
Winnicott	1930’s onwards	Psychoanalytic observations, holding, and ‘good enough’ mothering
Bowlby	1944 onwards	Maternal observation, maternal presence, and attachment theory
Bion	1962 onwards	The theory of the container and containment

Table 5

Acquarone ([54], p.160) states, “In 1931, Winnicott initiated Psychoanalytic consultations with parents and their children” Winnicott [39-43], Bion [37,38], and Bowlby [27,53,55-58] began their considerations in relation to infant mental health and the relationship between mother and infant which span decades. “Bowlby’s major conclusion, grounded in existing experiential testimony, was that to reach optimal mental health,” [4] “the infant and young child should experience a warm, intimate, and continuous relationship with his mother (or permanent mother substitute) in which both find satisfaction and enjoyment” ([53], p.13). Here we acknowledge Bowlby’s focus upon the availability of the mother and in considering an opposing stance, his unspoken concern regarding the absence of the maternal figure [4] which may equate to not being physically present or a lack of emotional availability through Birth Trauma, PTSD, Postpartum Psychosis, Perinatal/Postnatal Depression or otherwise. However, as Tronick [20] points out “The processes of mutual regulation moving towards a goal are neither simple nor straight-forward most of the time and do not run smoothly.” Tronick’s [20] comment serves as a poignant reminder that the environment, the attachment history and “internal working model” [27] of the parent(s), any and all experiences of early trauma in the ‘m’other, the level of maternal “reflective functioning” [28] the type and experience of conception, the pregnancy, all matters in the unique maternity and the availability of a PIP service that serves well in meeting the needs of the parent(s) and infant(s) concerned, are all key matters in relation to PIP.

Exclusion in PIP

I have considered the importance of PIP and the possibility of exclusion. Which groups or individuals are being excluded?

The National Perinatal Mental Health Project Report ([59], p.3) suggests “Relatively little is known...to what extent current provision meets the needs of black and minority ethnic women. (BME).” This demonstrates a clear need for more to be known about BME ‘m’others and PIP.

The Deaf Community and PIP

“Deaf people are a highly oppressed group who show many of the same characteristics seen in other oppressed people of the world” [60]. Deaf parents are not excluded from creating a secure attachment with their infant as a result of their Deafness in that “mutual visual interaction is in effect the earliest opportunity the mother-infant dyad has for communication” Volterra [61].

As 50% of my clinical work is undertaken with the Deaf Community I have considered the importance of PIP and the possibility of exclusion. Deaf women in my practice report experiencing oppression through a lack of cultural, linguistic and community insight. PIP may need to develop their knowledge and insight in to the world of the Deaf Community and in particular the Deaf parent.

Inclusion of Deaf parents in both service advisory matters and service provision in PIP ought to be considered. Four babies are born deaf every day in the UK (data from Newborn Hearing Screening Programme, 2008). For further consideration are the 10% of Deaf Parents raising both hearing and Deaf children. Ninety percent of all deaf children are born to hearing parents [62,63]. These 90% of Deaf children will be born into families where little if anything is understood in relation to the Deaf Community “The traditional medical construction of deafness...implies that deafness is a biological disorder or deficit that should be corrected” ([64], pp19-20). Some Deaf people might see themselves as being part of a cultural and linguistic minority. They may hold “the notion that [they] are members of a bilingual-bicultural minority group” ([65], p xi). There is a need to include the opinion of not only hearing people but of members of the

I have offered the examples above in deliberation of access and inclusion but many other minority groups will also need further consideration.

Contemporary PIP Timeline Critique

At the core, contemporary PIP clinicians are considering attachment theory [66-70], infant observation and working with the parent-infant relationship. Stern [26] suggests a focus on the ‘motherhood constellation’, which contemplates the significance of the relationship between the new mother and her mother, the new mother and her infant and the new mother and herself. In addition, the relationship the new mother has with the father of the infant requires consideration. Aside from Sansone [71,72], many in PIP are working from a psychoanalytic perspective. Sansone [71,72], considers a different paradigm. She postulates “a focus upon the empathic relationship and the symbiotic connection: where the relationship between infant and mother in utero and are seen as vital and where understanding of the relationship to the body and mirroring between mother and infant, are seen as catalysts for the mother’s empathy and understanding of her infant” [4].

Key Clinicians IN Contemporary PIP Timeline

1971	1980	1985-1986	1985	1986
Brazelton, Young and Bullowa	Dowling, Cramer Johnson and Wesner	Cramer and Stern	Stern	Boukidys
1994	1995	1997	2004	
Schore	Perry	Fonagy	Sansone	

This timeline demarcates work from 1971 onwards. Each year points to the beginning of the work and many are still working in the field of parent-infant mental health. Aside from Sansone [71,72] the clinicians listed are working from a psychoanalytic perspective. Sansone posits an integrative approach beginning at conception/early pregnancy.

Key Clinicians IN Contemporary PIP Timeline

Key Clinicians	Date	Clinical Focus
Brazelton, Young and Bullowa (USA)	1971	Work with mother to focus upon the distress of the infant
Dowling, Johnson and Wesner (USA)	1980	Developed a maternal infant programme, observing the dance of attunement between mother and infant
Cramer (1985) and Cramer and Stern (1986) USA	1985 and 1986	Work with mother to understand more in relation to mother-infant issues
Stern USA	1985, 1995 and 2000	Interpersonal aspects of the mother-infant relationship Developmental needs/Domains of Core Relatedness. Motherhood Constellation
Fonagy UK USA	1997, 1998, 2002	Preventative interventions in infancy, reflective functioning, and mentalisation. Psychoanalytic perspective
Perry USA	1995	Recognition of importance of early emotional experiences and the impact upon 'hard wiring' of the brain/neuroscience
Schore	1994, 2000, 2001, 2002, 2005, 2006, 2009, 2010	Affect regulation. Attachment and right-brain development. Neuroscience, Neurobiology of attachment. Relational Trauma and the developing right brain
Sansone	2004, 2007	Work from conception planning, pregnancy and throughout the perinatal period. Supporting the mother to connect with her infant in utero. Neuroscience. Multi-disciplinary, integrative approach. Working with all observation, mind-body connections with a relational approach. Empathic attunement. Mirroring in infancy. Prevention through early PIP work. Working with infants, mothers/fathers. Father's presence deemed imperative and attuned in order to support maternal mental health.

Table 6

Neuroscience and Environment

Neuroscience has provided us with a platform to understand more in relation to the effects of trauma upon both the brain and body [73]. Furthermore “Neuroscience...provides compelling evidence that early experiences impact on brain development, and can have a long-term effect on wellbeing (this includes physical and mental health, learning and behaviour)” [74]. “Nowhere does the making of a brain become more obvious and observable than when a carer engages with her infant” [73]. Moreover the interconnectedness or lack thereof between parent and infant notably impacts the developing brain of the infant. Schore [35], specifies that ‘right-brain’ to ‘right-brain’ connection between mother and infant encourages, ‘affect regulation’ in infancy.

Nurturance from a caregiver provides a springboard for psychological and physical wellness or - when this is deficient, mental illness and physical ill health. Infants and their caregiver relationships are of specific importance because of the developing infant brain and the neuroplasticity associated Cozolina [75]. This said, “A major conclusion of the last decade of developmental neuroscience research is that there is now agreement that the infant brain is designed to be molded by the environment it encounters” Thomas., *et al.* 1997, p. 209 ([31], 2001, p.12). Sabel posits “Evidence suggests that early parent-infant attuned interactions lay an important foundation for the child’s later emotional, social and cognitive development” ([76], p.23). Therefore if the environment is sensitive to the infant, the infant brain will be

shaped accordingly. However, “those who study interpersonal neurobiology believe (and research supports) that any meaningful relationship can reactivate neuroplastic processes and actually alter the structures and biochemistry of the brain” ([75], p. xviii).

Summary

Although much has been written in terms of Infant Mental Health and the early pioneers of PIP, there was a sense of contemporary PIP being very much in its infancy stage and very little has been written in relation to it. This supported the notion that there is much to learn about contemporary PIP practice.

The significance of the responsibility of the PIP clinician emerges; the power of those involved and magnitude of the tasks in early clinical work are brought swiftly into focus. Reaching the needs of all of those who necessitate PIP is beginning to seem like a gargantuan task. The costs of facilitating PIP work and the socioeconomic costs when this work is not undertaken are significant.

Excellent supervision and self-care arise in the embodied sense of the literature review. A curiosity in relation to the models of practice emerges. Training in PIP...perhaps? Access and inclusion are for further consideration. The voices of all parents and those who might consider themselves ‘experiential witnesses’ hold an imperative quality. A compassionate approach seems paramount.

Moreover, through socioeconomic and cultural factors the caring professions have power over the patients or clients served. They are dominant in their use of imagery, language and meaning-making of clients. They are the ‘key holders’ and ‘rule-makers’ of access/inclusion, eligibility and referral. In effect the caring occupations hold philosophical power. This said, the voice of any profession is not unilateral; it is diverse [77].

These matters have been illuminated through this review and they are the gaps for consideration.

Rationale

Westergaard ([78], p. 176) suggests, “Every profession or academic discipline is dependent on research.” This study oscillates around the need for psychotherapeutic practice, which places value in continually striving to learn and develop insight in all areas of contemporary psychotherapeutic work. PIP, contemporary in nature, offers an opportunity to develop research into a relatively under-researched, developing field. PIP is part of the psychotherapeutic field and there is little in the way of research to understand more in relation to contemporary UK PIP Practice.

Research Aims

“The aim of this research project was to explore, by relatively unstructured, in depth interview specific aspects of an individual” [79] clinician’s experience of PIP.

This research considers the practice of PIP as understood by the clinicians themselves. It aims to include knowledge of any variables in contemporary application to those already working in the field and matters deemed interesting to ‘m’others with a curiosity in relation to PIP.

Chapter 3

Methods

Introduction

This section provides information relating to the methods used in this research. I offer an introduction to qualitative research, Interpretive Phenomenological Analysis (IPA), the research methods, online interviews, snowball sampling, sampling and selection, a critique of the methods, ethical matters, sample size and a section entitled reflexivity and transparency which highlights a reflexive and open account of my ‘lived experience’ of undertaking this research.

Qualitative Research

Qualitative research seeks to designate meaning and interpretation through in depth study of a specific topic, in this case individual Parent Infant Psychotherapy, interviewing four professionals involved, to seek meaning and understanding of “the subjective experience” ([80-83] p.33) of those practicing in a “young, expanding and evolving” ([84], p.1) field, with a view to capturing “people’s experiences in context” ([8], p.5). “Between three to six participants” is deemed to be a “reasonable sample size” ([80], p.51). This research design incorporated the voices of four participants, who work in an expanding but relatively undersized field. The data were explored to discover divergent and convergent themes.

In undertaking this qualitative research I have approached the analysis using Interpretive Phenomenological Analysis [85].

Interpretative Phenomenological Analysis (IPA)

“Interpretative phenomenological analysis (IPA) is a recently developed and rapidly growing approach to qualitative enquiry” ([80,81], p.1). The origins of IPA are most often found in the field of psychology but are increasingly utilised by those in clinical practice in psychotherapy and health sciences [80,81]. As a phenomenological researcher my aim was to provide a rich, resonant, textured description of ‘lived experience’ (Finlay and Ballinger, 2006). “IPA as a phenomenological methodology is concerned with the nuances of how phenomena are experienced and made sense of” (Bright and Harrison, 2013 p.91).

Research Methods Defined

The aim was to explore the transcribed interviews with a ‘phenomenological eye.’ Specifically the method chosen can be defined as interpretative phenomenology analysis using a reflexive, relational approach [4,79]. In preparing an Interview Schedule and collecting the data I endeavored to “enable the framing of the research question and allow participants space to explore different aspects of experience” (Bright and Harrison, 2013 p.91). The Interview Schedule included nine “open and expansive” ([80], p.59) questions with prompts.

“It is fair to note, my research is only offering my interpretation of the data” [4,79]. “Any one analysis, says Churchill (2000 p.164) can only be presented as a tentative statement opening upon a limitless field of possible interpretations” ([8], p.146). “Research participants interpret their own worlds and, despite researchers’ best attempts to bracket off their own presuppositions about participants’ worlds, it is not fully possible to do so” (Bright and Harrison, 2013 p.89).

IPA researchers are trying to make sense of the world of the participant, whilst they (the participants) are trying to make sense of their experience of being interviewed. “Thus, in effect, researchers experience a *double hermeneutic*” ([8], p.35). Bright and Harrison, (2013 p.89) expand upon this and suggest “we might even experience a triple hermeneutic turn: *the reader making sense of the writer making sense of the participant, making sense of X* (ibid. p.41).”

As the analysis process is seen as “iterative” ([8], p.28) in whole and parts; the hermeneutic circle and meaning-making are seen as fluid and ever-changing, indicating an ebb and flow in divergence and convergence in data, which attempt to understand “the whole through grasping its parts, and comprehending the meaning of the parts divining the whole” ([86], p.9). In consideration of reference reflexivity I have accessed material, which resonates with the field of PIP that will be influenced by my worldview and ‘perinatal lens’ that will embody some of my position. In providing you with my felt sense of engaging with this research, I have spoken openly of my own ontological and axiological positions.

Online Interviews

“Qualitative research of an in depth nature is oftentimes based upon recorded interviews which are subsequently transcribed” [4]. Interviews are oftentimes undertaken face-to-face but due to time limitations, and minimising absence and costs, I completed the interviews online. However, in adopting [relatively] new methods, researchers can improve the adeptness and validity of their work [87].

The interviews were recorded using an independent recording device and through computer installed software. In recognising the professed benefits of authenticity in relation to recorded data, I am also struck by the lack of embodied meaning for the reader in the transcribed data. Transferring the 'live data' to the symbolic written form, a loss of richness and authenticity emerges [87].

Snowball Sampling

In order to recruit participants the use of snowball sampling, "which amounts to referral by participants" ([80], p.49) was deployed. Verification of participants was completed using social media and Internet search engines as tools to confirm identity.

Selection and Sampling

The considerations associated with a specific approach to sampling vary substantially and they echo the purposes and subject matter of the study [88]. Participants were selected on the basis that they grant access to the phenomena being studied [80]. Denscombe [89], suggests sampling, which is non-probable in form, offers itself to qualitative studies, which are small in nature and intend to explore the lived experience of participants.

Snowball sampling was applied to connect with the participants working in PIP through the support of the initial participant. Contact with major and smaller organisations currently providing PIP and PIP training was completed. A poster was created and posted on social media sites, including LinkedIn, Facebook and Twitter. "Informed consent" ([80], p.53) was given by all participants and the issued schedules were returned with signatures where required. Anonymity was offered [80] and data that may identify them was removed.

The sample of four female PIP clinicians was taken from UK.

Critique of Methods

IPA [85] was selected above other forms as it sits "within the family of interpretivist methodologies" ([80], p.93). In addition, it supports the notion of "the lived experience as fundamental" (Bright and Harrison, 2013, p.129) and enables the voices of the participants to be heard and deeply understood [90]. IPA promotes multiple levels of interpretation [91] and supports in stimulating "creativity and freedom to explore" ([92], p.99) in search for "gems" in the data to enrich the study ([93,94], p.7).

This does not mean as a researcher any less value is placed upon other approaches, it simply means other approaches and the appropriation thereof maybe more aligned to the needs and the ontological positions of other studies (Bright and Harrison, 2013).

In critiquing my methods further, an even more purposive method would be implemented in future research. Then again, "research, like life is not however always neat" ([80], p.95). There were times where my resources became "stretched" ([80], p. 97). The time required to reach organisations involved in PIP/PIP training, and jumping through 'organisational hoops' far outweighs the time frame. Further consideration of 'search and contact' time required for academic research into PIP is noted.

In further critiquing my research methods, I would prefer for additional research, to complete research interviews face-to-face. As, "...face-to-face interviewees are more likely to share...stories, which...provide additional data that online participants do not generate..." (Campbell., *et al.* 2001; Nicholas., *et al.* 2010; Synnot., *et al.* 2014)" Bowden and Galindo-Gonzalez [95].

Ethical Matters

"Most research requires some form of ethical approval" ([80], p. 105) and following receipt of university ethical approval, the work began. During sample selection process, and establishing the interview scheduling; I provided via post or email, each of the participants with details regarding the nature of the research: the methods allocated for information gathering, storage of data, recording methods, data protection, confidentiality and anonymity matters, and destruction of data. In order to ensure a full interview recording was available, the recording software was set to begin at the start of each interview. Prior to beginning the online call each participant was reminded of the

recording and the participant was free to request to terminate at any time. The recording software selected accommodated this and, in familiarising myself with these a successful back up was recorded on the secondary device.

Following advice from my supervisor, the use of Vsee was deployed. VSee is a non-cost Voice over the Internet Protocol (VoIP). Some of my research participants did not wish to utilise Vsee. They preferred the use of Skype.

I aimed to interview for approximately one hour. The mean average for the semi-structured interviews was 42 minutes, which is slightly less than the 45-90 minutes suggested by Smith, *et al.* ([80,81] p.60). I advised the participants that the material gathered would be analysed using IPA and that the material may be used for this research or subsequent papers etc. A further comment informed participants they had the “right to withdraw” ([80], p. 53) at any point before 31st March 2016.

All of the interviews were recorded and each was transcribed verbatim. All schedules were returned with informed consent.

Sample Size

“As it is important that participants have some experience of the phenomenon in question, IPA researchers usually try to find a fairly homogenous sample, for whom the research question will be meaningful” ([80], p 49). The research hoped to attract and engage with five to six participants who could provide data that was rich and satiating, but the time to gather data was diminishing quickly and the lack of available participants was becoming obvious. I also recognised it would have been “inadvisable” (Bright and Harrison, 2013, p.91) to involve too many participants. During the analysis similar and strong themes surfaced and as a result a “saturation” (Bright and Harrison, 2013, p.136) point emerged.

Reflexivity and Transparency

“The concept of *transparency* refers to the way a researcher is honest, authentic, and open about his or her method of work, beliefs/values, personal experiences and responses” ([8], p.110). In the spirit of considering the above, I have mentioned the request of some participants requesting the use of Skype instead of VSee and I aim to offer you some of my thoughts on the process of undertaking this research that encapsulates personal information and considered disclosure.

It is fair to note, I experienced some defeat in relation to finding willing and available participants. This search at times proved both futile and exasperating; it held a seemingly familial and disappointing quality. At times, I began to feel like a small child whose sole aim was to interrupt her busy parents by trying to attract their attention; this was a familiar feeling to me as child. At other points I felt like a disobedient child trying to find PIP ‘parents’ who were willing to share their ‘holding the baby’ experiences. There was also a quality of ‘go and ask your father’ only to be told by ‘my father’ that I ought to go and ask ‘my mother’. This experience was generated as a result of experiencing what I have defined as ‘organisational policy’ and possible ‘organisational politics’. I had made contact with many of the UK organisations involved in the provision of PIP Services and met with some institutional barriers. I began to consider my own unwillingness to engage in perinatal and postnatal services, this sense was compounded by an apparent lack of contact from some of the lead organisations involved. If I, as a PIP clinician, could not reach the ‘parents’ of PIP I began to wonder how accessible PIP services would be to services users. I felt an undercurrent of an ‘overly protective parent’ which did not fit with my transparent and reflexive style. On more than one occasion I considered ‘throwing the baby out of the bath water’ but the anxious-perfectionist part of me couldn’t let go.

Further disappointment arose in securing the voice of male PIP Clinicians. I had received an email from one male PIP clinician and my excitement rose. I tried to contact him via both email and mobile but he failed to respond to my contact. This ‘absent father’ further enhanced my sense of disappointment.

A supplementary frustration came in the form of my original participant four. Participant four and I made no less than four attempts to schedule and reschedule the interview. Eventually this proved too difficult and at the eleventh hour this never materialised. These contact difficulties did not dampen my tenacity but they proved to be bothersome and of concern.

This said, and of significant importance, the participants I did find, proved to be unambiguous, passionate, exceptionally well-educated ‘ever-present mothers’ in the developing field of PIP. Their approaches, the work in which they are engaged and their ‘good enough mothering’ in the field of PIP are analysed and explored in this unfolding story of contemporary PIP.

I knew three of the participants, and as a result it was important to consider the concept of “research allegiance”. Although previous studies into research allegiance have proved to be inconclusive my knowledge of the subject made me consider the possible impact on the research. The three participants known to me I met ‘virtually’ through Social Media. Two of the three I presented alongside at an international conference in 2013 and the third participant I first met through contact via LinkedIn. I did not know participant three.

I have made mention of experiencing maternal mental health difficulties and these include experiencing antenatal anxiety, postnatal depression following one of my infant losses and two particularly harrowing surgeries, which resulted in a postpartum psychotic episode. This episode occurred directly after the surgeries and my first infant loss. This said, I knew very little in relation to PIP during these emotion-fuelled times. Lastly, I experienced birth trauma following an invasive and harrowing midwifery intervention. This left me feeling traumatised and in significant pain. In seeking to formalise a complaint in relation to this, accurate notes had failed to be included and in my opinion purposefully omitted. These traumatising events cannot be extricated from my ‘psyche’ and yet they have proved to be particularly useful in working in PIP. We are all unique in our experiences of mental health but these significant and personal events have deepened my understanding of maternal mental health matters gifting me with an embodied experiential sense.

In honour of reflexivity, my willingness to share openly and honestly my lived experience of undertaking this research is stated. I cannot extricate myself from my own experiences of Perinatal/Postnatal mental health and Birth Trauma nor can I disregard my truth in relation to my disenchantments. It has been provided in the spirit of openness, transparency, and reflexivity and specifically with regard to IPA. “IPA maintains a strong connection to its ideographic roots, which aim for an in-depth focus on the particular and a commitment to detailed finely textured analysis of actual life and lived experiences” (Shinebourne, 2011, p.47).

Chapter 4

Data Analysis

Introduction

This section provides the reader with information on participant data, data analysis, superordinate and subordinate themes, and specific quotes and IPA analysis.

Participant Data

Participant	Education	Training	Practice	Gender
P1 ‘Grace’	Postgraduate	Integrative	Integrative	Female
P2 ‘Constance’	Postgraduate	Psychoanalytic	Integrative	Female
P3 ‘Agnes’	Postgraduate	Psychoanalytic	Integrative	Female
P4 ‘Elisa’	Postgraduate	Psychoanalytic	Integrative	Female

Table 7

The participants found for this research all share postgraduate level training and three of them hold doctorate level education. Three of the participants trained in traditional psychoanalytic models and participant one, ‘Grace’, trained in psychology and professes an integrative stance. All of the participants use a multiplicity of models in working with parents and infants. None of the four participants defined themselves a ‘purely psychoanalytic’. I have defined them as Integrative in practice. Three of the participants are mothers. During the initial data analysis I believed all of the participants were mothers. In checking with ‘Elisa’ she stated she was not as yet a mother.

Data Analysis

Qualitative research of any kind requires “requires researchers to immerse themselves in the data by reading, re-reading” (Bright and Harrison, 2013, p.145) and re-listening to the recordings of each of the participants. This process was completed many times to “ensure iterative engagement and phenomenological saturation” (Bright and Harrison, 2013, p.145). With curious eyes I trawled the data for mirrored themes, embodied meaning, attunement, mis-attunement and hidden “gems” ([93,94], p.7). In “immersing [myself] in detailed line-by-line analysis” (Bright and Harrison, 2013, p.136) I noticed a number of possible themes emerging. I analysed “each transcript to extract the phenomenological nuances offered by each participant” (Bright and Harrison, 2013, p.136). Once I reached “saturation” (Bright and Harrison, 2013, p.136) I noted the emergent themes. In support of extracting meaning I created individual theme tables. This ‘sitting with’ and ‘dwelling upon’ process helped me to “look at the internal consistency, relative broadness, or specificity of each emergent theme” ([80], p.99). Each of the five emergent superordinate themes provided a total of 12 sub-ordinate themes. The superordinate and subordinate themes were noted and a table (see table 5) created to portrait the themes. A Master Table was created to provide quotes from all of the participants to highlight the themes.

Superordinate and Sub-Ordinate Table

Superordinate Themes	Sub-ordinate Themes
Prevention	Working from conception Mindful maternity matters Working with the source problem seen as preventative
Model	Hyper-specialism and Universality Working proactively with non-verbal observation
Compassionate/non-judgmental approach	Parent-infant led service provision Access to PIP Self-care in PIP
Observation	Sharpening and enhancing observational skills for all in maternal mental health Non-verbal observation and mirroring seen as key therapeutic tools
Parental Attunement	A mindful approach to working with parents Parent(s) attachment/inner working model

Table 8

The superordinate/master themes with transcript extractions for the participants have been produced in table form. The tables include extracts of commentary to demonstrate the presence of each theme.

There was a universal merging across participants yet there were differing and divergent themes emphasis transversely noted throughout.

Prevention

All of the participants mentioned prevention and early intervention. Three further subordinate themes emerged 1) Working from conception/pregnancy 2) Mindful maternity matters 3) Working with the source problem seen as preventative.

Grace proffered a hint of prevention when she says,

“it was novel, there were not many people doing it back in 1979” (Grace: 41-43).

The fact that Grace had been undertaking PIP work since 1979, held for me a preventative quality. I began to consider how much preventative PIP work she could have undertaken over this 38-year period and how many parents and infants have been prevented from entering adult and child mental health service provision.

Constance suggests,

“...eastern philosophy, psychology which is very focused on prevention and the west...it's still lacking in...its interest in prevention...” (Constance: 377-381).

In ‘dwelling’ with this, I wondered whether the concept of eastern and western philosophy was a metaphor for a more personal form of frustration; Constance’s transcript leans towards an Eastern perspective and as a result of extrapolation infers contemporary UK PIP does not consider prevention in this way.

Furthermore Agnes refers to prevention in relation to three key areas 1) working in PIP as it early and therefore preventative. 2) preventing mental health problems/diagnosis and 3) commissioners not providing funding is preventing the work of PIP.

“...preventatively in early...” (Agnes: 18)
“...preventing diagnosis...” (Agnes: 25)
“...preventing children getting MH problems...” (Agnes: 116-117)

There is a ‘mission’ quality with regard to preventing children from mental health problems and diagnosis. I was further curious in relation to the personal ‘mission’ of Agnes. An undercurrent of urgency was present.

The first subordinate theme 1) working from conception/pregnancy transpired in the transcript of Constance.

“...if we could teach the mothers to interpret the movements, to respond by touching the belly, by talking... I think a lot of, attuned communication... could be established before birth” (Constance: 420-425).

Constance believes PIP should begin in pregnancy or possibly in conception planning. She deems mother-infant connection in utero as providing a solid base for mother-infant relations and attachment.

In further support of 2) Mindful Maternity Services subordinate theme Elisa states,

“It doesn't discriminate...treating this [perinatal and postnatal wellness] as part of... your antenatal parent course before you give birth...” (Elisa: 800-806).

Elisa, by proposing parental perinatal/postnatal health understanding in the antenatal period is proffered. There was a sense of urgency here and a further feeling of ‘the earlier the better’. Elisa’s focus seems to be upon meeting and treating the masses, rather targeting the few.

Constance further notes,

“...so what happens is because of training if...the pregnant mother...see[s] the midwife, the midwife will approach the mother according to her training unless she has done self-development...” (Constance: 487-493).

I interpreted this as, if a maternity (GP, Gynaecologist, Midwife, PIP etc.) clinician works without a deep understanding of their own ‘internal working model’, a deeply embodied, whole self knowledge and an overarching, compassionate approach with a mother, then problems will be present from the first point of contact which will provoke an “unthought known” (Bollas, 1987) response in the mother;

which for better or worse, could reignite the “mother constellation” (Stern, 1991) or traumatise the mother from initial clinical contact. This wound could be carried into pregnancy and beyond.

Constance further suggests,

“...we need to build a universal paradigm...a common paradigm in most professionals, a common language...mindfulness because...actually we need to build a universal paradigm...” (Constance: 456-460).

Here Constance is offering the concept of “mindful maternity services”, with skills congruent with self-awareness; attuned clinicians providing a common and compassionate way of working with ‘m’others during and beyond pregnancy: a shared way of working to support the ‘parent-infant dyad’.

The third theme 3) Acknowledging and working with the source problem seen as preventative transpired,

“if you go into a house and it’s...flooding, you...turn the tap off first... rather... you...go...where’s all this water coming from, [to] try and get it at the source” (Agnes: 796-805).

Elisa further states,

“it has its roots in...infancy so it’s like a breadcrumb... trail that you’re trying to follow back to close those gaps” (Elisa: 247-249).

Both Agnes and Elisa proffer powerful visual imagery in their transcripts here. They were both with reference to seeking the root of the problem in reaching parent-infant relationship as early as possible in order to prevent further problems arising. Further qualities emerged in the utterances; how difficult would it be to have to literally follow a breadcrumb trail? How terrifying would it be to experience flooding? Here I noted a further sense of urgency.

Furthermore Agnes suggests,

“...it’s about saving money and the commissioner’s just kind of not getting it...” (Agnes: 567-569).

In Agnes’ statement I sensed frustration, which was married with passion for service provision.

Prevention transpired from a number of viewpoints including; prevention and early intervention (pre-conception, conception, pregnancy and in the perinatal period), beginning the work in conception planning and pregnancy could mean the potential prevention of problems in the postnatal and subsequent period, prevention of trauma relating to the interaction with those involved in maternities, prevention of diagnosis, prevention of mental health problems, prevention of PIP due to funding constraints, prevention of further expenditure in later life, and a lack of interest in prevention in our western PIP culture. There was an undercurrent of urgency in this theme.

Model of Practice

Much of the work in PIP is psychoanalytic in nature. In uncovering more in relation to contemporary PIP I note a ‘sea change’ in current practice. This theme provided two subordinate themes 1) Hyper-specialism verses universality or commonality and 2) Working proactively with non-verbal observation.

Constance suggests,

“...there is an urgent need [for a] multi-disciplinary integrative vision” (Constance: 931-932).

A compassionate, attuned, empathic service provision across maternity service providers, to work with ‘m’others at a significant time was proffered. The theme of urgency transpires once more.

Agnes who also trained as a Clinical Psychologist and is undertaking specific PIP training suggests,

"...this training in parent infant psychotherapy I'm doing, they're making it up as they go along..." (Agnes: 667-670).

which seems like a damning indictment of a current training in the field of PIP. She indicates she has used her clinical training (which I would describe as substantial) and experience and has

"...made up [her] own model..." (Agnes: 268).

These comments are striking. In consideration, the following recognition transpired – If they are making up their training model, I am making up my own too!

Elisa who

"did an undergraduate in psycho-analysis and then...a...clinical masters in clinical psychotherapy...a psychoanalytic model" (Elisa: 149-152),

then goes onto to say,

"...I did a post grad in play therapy..." (Elisa: 164-165)

In addition, Elisa has furthered trained,

"... in... Theraplay and Theraplay (which is a dyadic attachment focused therapy but it starts with an assessment called a MIM), a Marschak Interaction Method..." (Elisa: 67-71).

Elisa's transcript demonstrates a 'sea-change' in her practice. She sailed well in her psychoanalytic ship for sometime before discovering the value of Theraplay and the Marschak Interaction Model, which seemed intriguing to me.

Two further sub-themes emerged. Firstly, in relation to hyper-specialism Constance states,

"...The problem is that... hyper-specialisation creates perspective... and the perspective make the professional see only one aspect..."
(Constance: 468-475).

She further states,

"the gap is hyper-specialisation..." (Constance: 505),

In reflecting upon these statements during and post the interview I was struck by the impact of Constance's observations. I interpreted this to mean, each maternity clinician is focused upon their specialty. This focus may impinge upon the clinician's capacity to see beyond the scope of their dominant skill set. This may result in 'missing' other potential issues such as latent depression in the mother, perinatal anxiety, OCD, domestic abuse, a history of child sexual abuse, addiction, or any number of other possible issues.

In relation to the second sub-ordinate theme 2) Working proactively with non-verbal observation Graces states,

"I would...share with the mother, you know...what I felt was going on, sometimes it would register in the body as a form of tension... and I would then highlight..." (Grace: 144-150).

This statement offered two components 1) the experience of Grace's bodily responses to the 'm'others verbal and non-verbal communication through a counter transference response, to inform the work and 2) the experience of the observation of the 'm'others body to further inform the work.

Constance suggests,

"[If] we don't ever pay... attention to this narrative, we miss the whole case and that... attention to the verbal and non-verbal language [simultaneously], if there is coherence, there is an end..." (Constance: 1195-2002).

Constance appears to be 'silently screaming' the importance of the observation of the verbal and non-verbal concurrently. She expresses a need for a coherent response to all forms of language from all involved in maternities. Her desire to support empathic nurturance is further apparent.

Compassionate and Non-Judgmental Approaches

The themes of compassion and non-judgmental approaches transpired in all of the transcripts. Three further sub-ordinate themes arose 1) Parent-infant led providing unique service provision 2) Access to PIP and Specialist Units 3) Self-care and compassion fatigue

Grace said,

*"I would share...being respectful.
it helped them to recognise... strengths...
[and] some of the difficulties..."* (Grace: 155-162).

Here Grace was referring to providing feedback and observations to mothers in the group. There was a gentleness and empathic quality here.

Constance states,

"...we don't have to be judgemental..." (Constance: 988-989)

In this utterance I felt like Constance held a protective maternal quality in relation to those experiencing maternal mental health or other issues. Her empathic nurturance further transpired.

Constance went onto to state,

"...to connect and to feel empathy with the pregnant mother because a pregnant mother is already a parent..." (Constance: 462-465).

Constance further states,

"...the midwife will approach the mother according to her training unless she has done self-development ...training or she's particularly skilled in terms of empathy connections but in this fast paced society it's very hard if you haven't gone through a self-body training...you [only] apply the theory you have learnt during your training and this is...where the gap is..." (Constance: 490-503).

I experienced this as a powerful utterance, I was struck by four factors 1) the need for all clinicians to be empathically connected 2) the perception of specific training creating a gap in service provision. 3) the suggestion that unless you have gone through your own personal psychotherapy or self-development then this will be difficult to achieve 4) our technological age may be unhelpful in keeping our empathic channels open.

In terms of sub-ordinate theme 1) Parent-infant led service provision.

Grace states,

"I tend to be more focused on the mothers or fathers experience" (Grace: 198-199).

Constance says,

"...walk together with the patient towards the healing..." (Constance: 216-217).

Agnes states,

"base it on what the family would find most useful rather than be driven by my particular decision about...my theoretical model" (Agnes: 449-453).

The above demonstrates a compassion and desire to work with what is most useful for the parents and infant, addressing the uniqueness of each dyad/triad, with relational warmth transpires.

In terms of subordinate theme 2) Access to PIP and Specialist Units.

Access to PIP services was mentioned in three of the four transcripts.

"...people who'll be influencing and making decisions... about where we put our resources..." (Agnes: 836-841).

A further notion of access came through in relation to only offering PIP to those who are known to be experiencing mental health problems and not access for all.

"...so without the latent problem, the pre-natal depression, which very often is latent, and is not seen by the professionals like midwives or obstetricians who don't see but because of their training..." (Constance: 448-453).

Once more, the theme of potential hyper-specialism arose.

In relation to subordinate theme 3) Self care and compassion fatigue.

Three of the four participants spoke of the nature of PIP and the need to be mindful of self-care and compassion fatigue.

"...it's very involving...work, emotionally...because...we...have to cope with our emotions...and not just with the mother...parents and babies emotions..." (Constance: 959-965).

This statement summarised for me the depth of the experience of working with the 'm'other-infant dyad and the need for proactive self-care.

Observation

Grace says,

"...certainly the experience of working with mothers and ...infants...really hard tuned my observational skills (Grace: 339-343).

This held a 'baptism of fire' quality. It suggested that the need for observation skills to be 'hard-tuned' was essential in the work of PIP.

Observation skills were seen as paramount. Yet Constance suggests they are,

"...lacking in most professionals..." (Constance: 82-83).

Constance further elaborates and says

"...[the] mission of a...parent infant psychotherapist is huge because [they have]...to bear in mind the mother, the parent and the baby and... be an extremely skilled observer, that's why observation...should be taken seriously..." (Constance: 534-541).

Here she relates to PIP professionals and training in PIP and potentially her belief that 'whole mind-body observation' is not seen as key in PIP.

The use of the phrases "hard-tuned" and "extremely skilled observer", make observation seem imperative in nature to the work of PIP.

Agnes states,

"...to...focus on those moments of attunement with the parent so that they can see..." (Agnes: 366-368).

Elisa says,

"...Elisa: "cos at the end of the day we all just want to feel felt and get gotten and that's what were supposed to have experienced in that parent infant experience is that, 'you get me, I get gotten by you and the world makes sense because you make sense of it for me and you reflect that back'" (Elisa: 646-653).

The two statements from Agnes and Elisa resonated deeply. Their attunement and compassion shone through. The value they placed upon attunement in PIP practice became even more apparent at this point.

The first of two subordinates 1) Sharpening & enhancing observation for in maternal services when Constance says,

"...I realised the importance of observation... for training to work with parents and infants..." (Constance: 77-80).

The second subordinate theme 2) Non-verbal observation & mirroring seen as key tools in maternal service provision.

Grace implies the group situation provides a mirroring experience between the mothers in the group.

"...because they were in a group situation there was a lot of sharing going on..." (Grace: 92-93).

Constance suggests that mirroring needs to be considered in both psychotherapeutic services and within maternal service provision.

"...mirroring...should happen in other settings..." (Constance: 572-573).

"What happens in a psychotherapeutic setting is continuous mirroring..." (Constance: 570-572).

Once again Constance utterances are powerful in relation to her perceived value of mirroring. She sees it as significant and therefore it's absence as critical.

The theme of observation was multi-faceted; observation of parents, infants and self in practice are seen as paramount, non-verbal observation of the parent-infant relationship and of the use of the 'embodied self' to analyse and work with the non-verbal were seen as important. Constance mentioned observation or a derivative thereof in excess of ten times.

Parental Attunement

Grace says,

"I recognise this was way beyond my own particular scope of psychotherapy and that she needed a psychiatric evaluation..." (Grace: 327-330).

Constance suggests,

"Omnipotence comes from a lack of attunement with your own self which is really the first care giver...teach[es you] how to do it..." (Constance: 1113-1116).

Agnes says,

"...and then they [parents] can start...to talk more about that and why they don't have many moments of attunement with their baby and...what gets in the way so...it opens up avenues for discussion as well." (Agnes: 388-393).

Elisa suggests,

"...so investing in parent attunement is the best, it's the greatest gift we could give." (Elisa: 62-64).

The range of commentary in relation to parent attunement encapsulates the need for its presence and the problems, which may arise from its absence. The concept of teaching parents to be more attuned as well as using parental attunement to springboard the parents into more positive parenting began to emerge.

Two subordinate themes were noted, 1) A mindful approach with parents and 2) Parent(s) attachment, inner working model.

In terms of 1) A mindful approach,

Agnes suggests,

"...and really thinking about the parents own experience..." (Agnes: 302-304).

Agnes' appears to suggest a need to consider the parents and their unique experience of being parented. Once again there was a quality of urgency in this expression.

Constance said,

"...mindfulness should be really... a universal language which...allows a professional, parent and babies to connect in a commonality..." (Constance: 559-563).

Constance considers mindfulness as a way of connecting the triad of parent, infant and professional. I further recognised her desire for a commonality in language and practice in supporting parents and infants in all clinicians involved in maternities.

In terms of subordinate theme 2) Parent(s) attachment, inner working model.

Elisa mentioned attachment 30 times and used the phrase "inner working model" 4 times in her interview.

Elisa states,

"I have a particular clinical interest in child attachment... in working with child attachment and mentalisation in parents" (Elisa: 37-41).

And she further suggests,

"...it's about accessing their inner working model and their attachment system..." (Elisa: 568-570).

Elisa elaborates further when she says,

"but how each of those layers of functioning within us have been formed as a result of projections, injunctions, permissions, counter-injunctions that have been projected into us from each of our parents from their parent adult child voice which they got from their parents..." (Elisa: 592-599).

Elisa elaborates and offers her perception of the 'layers'. Her utterance here includes her perception that these layers are what 'we' all carry and not just those she works with. It holds realistic and inclusive qualities.

Summary

The theme of prevention was one of the strongest in this research. All of the participants mentioned it in one form or another. There are many further examples of prevention in the transcriptions but the themes and sub-themes mentioned above covered all of the aspects.

The model of practice theme suggests many variables in contemporary PIP Practice.

The theme of compassionate and non-judgmental practice emerged with clarity. The idea that all in maternity services need to be practicing with this model emerged too.

Observation of self, parent and infant dyads and triads, and the potential use of 'other' and 'self' embodied observation to provide feedback arose.

Parental attunement is closely linked to compassionate and non-judgmental approaches. The idea of healing through meeting individual needs regardless of model also transpired. 'Birthed' within the transcript of Elisa was the concept 'we' have all experienced something in our early attachment relationship, which is embodied within each of us, which intertwines us in a universal connectivity.

Chapter 5

Discussion

Introduction

The meanings extracted from the conclusions could provide current discourse for those with an interest or investment in PIP.

With the use of openness and bracketing [7] I pondered upon my own assumptions and possible preconceptions e.g. my assumption that most PIP Clinicians would be practicing psychoanalytically; post analysis my preconceptions were revised and further original perceptions materialised. The original literature (Chapter 2) was re-explored and as additional and innovative themes transpired from my analysis further literature was reviewed.

Who is Holding the Baby?

Firstly, in critically analysing my findings, I am unsure whether or not I have attracted a representative majority or minority of PIP clinicians in the UK, but what I am sure of is that these PIP clinicians are working with all of their clinical skills to meet the unique needs of each and every 'm'other, father and infant. They are all highly educated 'mothers' who are 'holding the baby', and 'nurturing the 'm'other' in their own unique and seemingly cooperative manner. They are not psychoanalytic in practice.

Prevention

The clinicians found for this research are thinking preventatively and with prevention in mind. Yet, aside from Fonagy [28,96-98], Schore [31,35] and Sansone [71,72] the literature reviewed promoted a reactive rather than proactive stance. Barlow, *et al.* (2013, p.2) discuss working with "a theoretically guided dyadic intervention that focuses on improving infant attachment by targeting parental internal working models." At this point there is already a known issue. This is the work of PIP clinicians but the theme of prevention transpired with wide-ranging possibility.

Fonagy ([96], p.126) states, "I firmly believe that the future of mental health work in infancy is in prevention." An alternative, preventative paradigm could include 1) empathic and relational assessment 2) empowering psych education at point of planning conception or at

first point of known pregnancy 3) teaching connectivity with infants in utero 4) provision of training in support of parent-infant connection 5) development of accessible and culturally meaningful PIP/training in the general field of psychotherapy.

Models of Practice

In order to demonstrate the fluidity in modern PIP practice the following core practice features were identified in each of the participants. Each of the four participants defined themselves as integrative and relational. None of the participants deemed their practice in PIP as purely psychoanalytic. They all worked with non-verbal observation and communication, using reflective practice, mirroring of non-verbal/verbal language and countertransference. The participants deemed parental attunement and a thorough understanding of attachment as paramount. They each work as individual clinicians with the dyad (individual parent and infant) or triad (both primary caregivers and infant).

Although, Baradon [15] suggests formal training in psychoanalytic clinical practice is necessary for PIP. Key components in contemporary PIP across the four clinicians included 1) Meeting the needs of individual dyads/triads “regardless of the forum or medium of delivery” ([99], p.164) 2) Teaching parents the value of parental attunement and using parental attunement to inform the work of PIP 3) Working with non-verbal observation of the self and the dyad/triad, as a tool to promote deeper understanding and optimal attachment 4) An integrative/multi-disciplinary model of PIP 5) The embodied use of mirroring in clinicians working in maternities and the teaching of observing and embodied mirroring in infancy to provide a solid foundation [100].

It became apparent that the participants interviewed have extensive clinical training and expertise. They appear to be providing parent-led PIP practice utilising a multiplicity of clinical skills and practices. None of the clinicians appeared to be working rigidly with one modality and they delved deep into the heart of their therapeutic depths, to utilise their ‘good enough’ therapy skills to serve the individuals in a compassionate and non-judgmental manner.

The training that is being undertaken specifically for PIP practice, provided by a singular PIP training organisation has, in this instance been disparaged. My perception in relation to participant 3’s statement and embodied observations led me to observe and experience a degree of anger, frustration and even an air of cynicism.

Compassionate and Non-Judgmental Approaches

The participants demonstrated their compassion, which related to ‘m’others, fathers, babies, the parent-infant relationship, perinatal and postnatal ill health and themselves. Their non-judgmental approach was in relation to PIP practice and the non-discriminatory nature of perinatal mental health.

The researcher (purposively) never made mention of PIP and minority groups in the questioning and none of the PIP clinicians made mention of it specifically, they made inclusivity for all appear in the text and subtext. PIP needs to address differences in culture, religion and class [13]. This said, “...when discussing parents with disabilities [or any other minority], it is important to keep in mind the diversity of...[each] population” [101]. We need to consider “strategies that promote incorporation of a cultural dimension within the therapeutic relationship” National Mental Health Development Unit [59].

Observation

Papousek and Papousek [102] suggest that, “learning how to communicate represents...the most important developmental process to take place in infancy”. This said, infants do not speak the ‘verbal language’ of adults. Therapists, clinicians and parents can use the “skills of observation to see, touch, sense, hear...and wholly experience” ([100], p. 16) the infant and ‘m’other. Furthermore, “through non-verbal visual-facial, tactile-gestural, and auditory-prosodic communication, the caregiver and infant learn the rhythmic structure of the other and modify their behaviour to fit that structure therefore” ([35], p. 20) embodying parent-infant attunement. This form of whole and em-

bodied observation and attunement could be used in the work of the PIP clinician if a heightened sense of the “rhythmic structure” [35] of the ‘m’other and infant is observed, much may be gleaned. Importantly, ‘right-brain’ to ‘right-brain’ connection between the therapist and ‘m’other to model for the ‘m’other a ‘way of being’ with her infant could provide a ‘relationally-centred’, embodied approach to PIP. The PIP clinician’s ‘way of being’ in relation to their embodied unique attachment histories needs to be in awareness; without this insight a rupture in the maternity relationship is likely to transpire. I would go further and state that this embodied practice is necessary for all clinicians involved in maternities.

“When I look I am seen, so I exist. I can now afford to look and see. I can look creatively and what I apperceive I also perceive” ([43], p. 3).

When attuned, compassionate, embodied, non-judgmental, ‘m’other/infant-led therapeutic work sees the connection of the therapist and ‘m’other in the work of PIP, a catalyst for healing in the therapeutic relationship is likely to emerge.

Parental Attunement

“Pearmain (2001) defines attunement as a sense of connectedness and focused awareness. She points to the subtly responsive rhythmic pattern of dialogue which emerges as attunement moves beyond empathic words” (Finlay [9], P52). Here we note the resonance and body felt echoes of clinical connectedness and the power of these moments in the therapeutic exchange.

Who is Holding the Parents?

This sub-heading relates to those providing training in the field of PIP: the ‘PIP Parents’, who are providing PIP Trainings and PIP Services. In hearing of Participant 3’s feeling in relation to her experience of contemporary PIP Training I felt both disappointed (in a parental sense) and sad. I am bothered by the perception of Agnes, her alleged experience of this training and where this leaves contemporary PIP. Although PIP is seemingly in an infancy stage a sense of frustration, loss and sadness emerges in this unmet need.

Lastly, as the contemporary vision unfolding in the heart of PIP began to emerge I began to feel excited. Therefore the questions that inspire me significantly are, what are the most useful ways to connect with infants and their parents in contemporary PIP Practice? How can this potential PIP model be defined? In determining a possible focus for future PIP research I am drawn towards equity in service and training; and a further area for examination could be an analysis of a ‘right-brain’ to ‘right-brain’ model in contemporary practice.

Summary

This journey has provided a path, not a fully-fledged road but a route to the contemporary heart of PIP. It has shone a light on a worrying matter in relation to current singular UK PIP training. It has broadened the scope for PIP in conception-planning, pregnancy and in utero. It has proffered a ‘right-brain’ to ‘right-brain’ Clinician-parent/Clinician-Parent-infant/Infant-parent reciprocal, synergetic therapeutic ‘nurturing circle’ which may hold restorative qualities.

Chapter 6

Conclusion

Introduction

This research is offering more suggestions in relation to prevention in PIP. It is proposing a parent-infant led practice; psychodynamic, integrative, relational model is at the heart of contemporary PIP. It further highlights observation, parental attunement and compassionate and non-judgmental approaches as essential to the PIP clinician.

Overview of Findings

Parental attunement and observation of the 'm'other-infant relationship are seen as useful tools in the work of PIP. The 'm'other-infant relationship in terms of neuroscience suggests a 'right-brain' to 'right-brain' connection to promote 'affect regulation' [35]. I posit that in order to regulate the 'm'other-infant relationship in PIP, a 'right-brain' to 'right-brain' connection in the therapeutic relationship is an essential consideration; it offers a form of 'psychotherapeutic mirroring' [100] to the 'm'other-infant dyad which is both "confirming and affirming" ([100], p.17).

The following has taken key components of Schore's model of affect regulation and right-brain development ([35] pp.24-27), and similarly Sabel's [100] The Blossom Method, in an attempt to demonstrate a contemporary 'right-brain' to 'right-brain' PIP paradigm/model.

I have addressed Schore's model of affect regulation and right brain development by considering 1) Right-brain affect processing 2) Right-brain regulation and 3) Right-brain communication processes ([35], pp.24-27).

Schore's identifies a regulated response and in doing so he suggests the following:

Right-brain affect processing

In order to regulate response in an infant when an infant is feeling positively aroused the mother provides a warm verbal and non-verbal response which matches the "infant's affect and positive arousal".

In consideration of "negative affect processing" ([35], p.24) and the provision of a regulated response to "a fussy, moody affect" which is expressed freely" the mother is able to tolerate their own negative feelings and participate in interactive care through the process of mutual attuning ([35], p.24).

Right-brain regulation

In consideration of interactive regulation an infant expresses and recognises affective facial expressions, vocalizations and gestures and the infant seeks out the mother to co-regulate the inner state. The mother does this by responding with arousal/regulating facial expressions, vocalizations and gestures. The mother therefore seeks to affect the infant's inner state of being. As a result, each member of the dyad (the mother and the infant) responds to the other's facial expressions, vocalizations, and gestures, which is providing a right-brain to right-brain connection. Here the mother and infant through interaction seek attunement. In terms of 'autoregulation', the infant may seek to self-soothe and the mother engages her own self-calming behaviours whilst each member of the dyad remains calm and regulates own state of being ([35], pp.24-27).

Right-brain communication processes

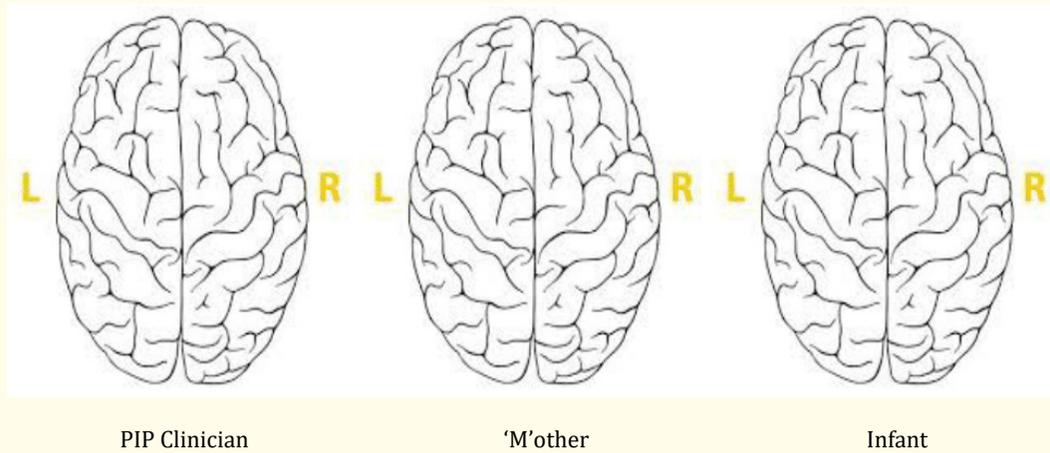
In consideration of right-brain communication processes Schore [35] suggests three areas 1) Visual/facial expressions 2) Vocal Tone and rhythm 3) Gestural and postural response ([35], pp.24-27).

Sabel (2012) The Blossom Method

Sabel [100] posits the use of The Blossom Method in parenting and in psychotherapy practice. The Blossom Method is based upon three simple components, 'observation, mirroring and responding' [100] to the infant (or client/patient) in order to provide a 'right-brain' to 'right-brain' connectivity in both parenting and psychotherapy.

PIP 'Right-Brain' to 'Right-Brain' Therapy

In terms of a PIP paradigm/model with a 'right-brain' to 'right-brain' connectivity I posit the above can be used in a therapeutic relationship where the parent-infant therapist supports affect processing, affect regulation and 'right-brain' regulation by using the non-verbal and verbal connectivity in their work with parent and infant. They would 'observe' the dominant non-verbal and verbal discourse of the mother. 'Respond' verbally and mirror non-verbally to demonstrate they are actively listening to the whole narrative and provide a 'dyadic visual-affective arousal regulator', and 'dyadic auditory-effective arousal regulation' or put simply a 'mirroring' which matches the dyadic tones and rhythms of the dyad. The therapist's body language (gestural and postural) would further match the dyadic rhythm whilst containing any personal response to the clinical work and sharing these responses with the 'm'other-infant at an appropriate time in the therapeutic work [35,100].



I posit a right-brain (therapist) to right-brain (mother) to right-brain (infant) way of undertaking parent-infant psychotherapy as most useful in contemporary PIP. The clinician would be 'wholly-observing' the infant-parent connectivity and would be 'mirroring' these observations and 'responding' through their visual, facial expressions, vocal tone, rhythm and gestural and postural responses, whilst 'therapeutically-holding' the parent-infant relationship [35,100].

The right brain hemisphere is more dominant in human infants [103] and in connecting the right-brain hemisphere of the PIP clinician and the 'm'other-infant dyad, through embodied PIP practice, a deeper level of attunement may transpire in PIP.

Access and Equity

There is a much-needed review of access and equity in PIP and in PIP training. There is a need to consider, Disability, Language, Deaf Culture, Black and Minority Ethnic Cultures; socioeconomic, social mobility, linguistic and religious matters with equity as a dominant principal. These ought to be considered as paramount in PIP training and clinical facilitation. Moreover, putting 'm'others and their families first and foremost is essential. They ought to be considered over and above clinical criteria, guidelines and pathways.

A Contemporary Definition of PIP

In terms of the lifeblood of PIP I posit the following in terms of a definition of contemporary PIP.

PIP – working with parent(s) and infant from point of planning conception to meet the individual needs of each parent with consideration of cultural, personal and other matters, serving to promote an optimal relationship between parent and infant. Facilitated through a multisensory, empathic, embodied 'right-brain' to 'right-brain' connection using relational therapeutic integrative practice, perinatal/postnatal education, attaching and regulating 'm'other and infant through promoting 'in utero' connection, teaching parent-infant interconnection through observation and mirroring [100]; and using parental attunement to connect the dyad/triad.

In a field that professes a psychoanalytic leaning this definition may not marry well. It does however mirror Schore's theory in relation to "affect regulation and right brain development" ([35], pp. 24-27).

Research Limitations

This research supports the notion of journeying into the heart of contemporary PIP but I wish to acknowledge the limitations in research [104]. It is a small scale IPA research and in a "feminized" profession ([105], p.4) it would have been advantageous to have a male PIP perspective. Although as a researcher I have made reference to minority perspectives I further recognise that the sample was somewhat limited in relation to ethnic origin [106-117].

Possible Future Research

There is a need for further research into contemporary UK PIP. This singular study may open the 'research door' for further studies. Research into 'right-brain' to 'right-brain' PIP practice could be considered. PIP and the Deaf Community is an area, which deserves further attention. Access, inclusion, equity and a multicultural perspective study into PIP could prove beneficial.

Summary

Journeying to the heart of contemporary PIP has posited a definition of contemporary PIP, which could proffer a more preventative, equitable model of practice; one which others involved in maternities may embody, thus avoiding a hyper specialist paradigm. It has identified the significant and various training clinicians are utilising in PIP. It has drawn attention to a concern in relation to a singular UK PIP training, which may serve as a prompt to analyse contemporary training, governance and the overseeing of PIP.

Final Reflections

This voyage of discovery has seen me sailing through calm seas and journeying through raging storms. At times I have felt a need to swim for my life and scramble for a life jacket. During the reflexivity section I recall the embodied feelings that eventually left me with a sense of floating in calm, tropical seas.

Courage and grit were required throughout. Determination to provide clean and honest reflexivity consistently became paramount. I struggled significantly with the confession of my maternal mental health experiences but I am satisfied the correct choice has been made. I stand up, I lay my shame to rest and I own my experiences.

The grumbling rage and deepest sadness associated with my birth trauma, infant losses and maternal mental health are embodied and accepted.

My journey to the heart of contemporary PIP is for now complete. I am satisfied that the courageous, generous offerings of all of my participants have enabled the discovery of more of the lifeblood at the heart of contemporary PIP. The 'conception' and 'birth' of this research has been quite a journey. Thank you to all who have encouraged me along the way.

Dedication

This research is dedicated to those who have lived with perinatal and postnatal experiences. It is also dedicated to my 'lost infants', my non-surviving babies whom I love and cherish in embodied memory.

I further dedicate this research to all of my clients and patients who have taught me through the sharing of their own struggles and unique, complex early years; the significance of infancy, childhood and beyond.

*"Being a parent is a true adventure.
As you sail through the smooth times,
you'll feel as if you're floating down
a river on a warm sunny day,
unable to wipe the smile from your face.
And as you struggle through the harder times,
it is as if you are climbing a mountain,
physically and emotionally exhausted,
yet you'll find relief and reward at the top"*
(Gordon [118], p.300).

Acknowledgements

I wish to further acknowledge my sincere and genuine thanks to the following individuals who have offered me, with consistency, steadfast support and encouragement throughout this research journey.

To my research participants “Grace”, “Constance”, “Agnes” and “Elisa” whose courage, compassion and commitment to infant and parent wellbeing made this research conceivable and to whom I am infinitely indebted.

To my research supervisor, whose guidance, flexibility, support and understanding, were an inspiration to me throughout.

To my husband and daughter for your unwavering love, patience and support, thank you. I am deeply indebted to you both.

To my clinical supervisor, whose compassion and resolute support serve to inspire.

To all of my friends and family who have struggled with their own issues and yet offered unconditional love and kindness throughout, thank you.

Finally to two significant mothers, my mother and my mother-in-law, I wish to acknowledge you both. To my own mother I love you and I wish to acknowledge the continual ‘gifts’ you and your deafness bring. Lastly, I wish to acknowledge Mama (my mother-in-law) who in December 2015 experienced a substantial and life-changing stroke. Your strength to thrive in the face of such adversity is a continual inspiration to me. I love you.

Note

- The terms /therapist/psychotherapist and therapy/psychotherapy have been used throughout this paper synonymously. The term clinician has been used to offer an umbrella term, which encapsulates the divergence of clinical background, and the significance of each of the participant’s training and experience in the wider field of infant mental health.

*“When I’ve had a week of one a.m. three a.m. six a.m. wakes
and my eyelids spend days in a half-closed/shut state
When you do fall asleep
and I need to sleep too
I can’t help staying up just to gaze at you” (McNish [119], p.110).*

Bibliography

1. Bauer A Parsonage., *et al.* “The Cost of Perinatal Mental Health Problems”. London: LSE/Centre for Mental Health (2014).
2. Everyone’s Business Campaign: Maternal Mental Health Alliance (2016).
3. Andrea Leadsom MP, *et al.* “The 1001 Critical Days: The Importance of the Conception to Age Two Period”. A cross-party Manifesto (2013): 5.
4. Sabel V. “Understanding Social Research and Evaluation”. Leeds: Leeds Beckett University (2016a).
5. Erskine RG., *et al.* “Beyond Empathy: A Therapy of Contact-in-Relationship”. New York: Routledge (1999): 2.
6. Cohen NJ., *et al.* “Wait, Watch and Wonder: Testing The Effectiveness of a New Approach to Mother-Infant Psychotherapy”. *Infant Mental Health Journal* 20.4 (1999): 429-451.

7. Finlay L. "Phenomenology for therapists: Researching the lived world". West Sussex: Wiley-Blackwell (2011).
8. Finlay L and Evans K. "Relational-centred research for psychotherapists: Exploring meanings and experience". West Sussex: Wiley-Blackwell (2009).
9. Finlay L. "Relational Integrative Psychotherapy: Process and Theory in Practice, Chichester". Sussex: Wiley (2015).
10. Barlow J., *et al.* "Parent-infant psychotherapy for improving parental and infant mental health". *Cochrane Database of Systematic Reviews* 1 (2015): CD010534.
11. Finlay L and Gough B. "Reflexivity: A practical guide for researchers in health and social sciences". Oxford, United Kingdom: Blackwell Science (2003).
12. Shaw RL. "Identifying and synthesizing qualitative literature". In D. Harper, and A. R. Thompson (Eds.) *Qualitative research methods in mental health and psychotherapy: A guide for students and practitioners* Chichester: Wiley-Blackwell (2012): 9-22.
13. Berg A. "Ubuntu – from the consulting room to the vegetable garden". In Raphael-Leff, J. (ed) *Between Sessions and Beyond the Couch*. Colchester: University of Essex (2002): 102-107.
14. Cleaver H., *et al.* "Children's needs – Parenting Capacity: Child abuse: Parental mental illness, learning disability, substance misuse and domestic violence". 2nd Edition. London: TSO (2011): 9.
15. Baradon T., *et al.* "The Practice of Psychoanalytic Parent-Infant Psychotherapy: Claiming The Baby". East Sussex: Routledge (2005).
16. Baradon T. "Relational trauma in Infancy". East Sussex: Routledge (2010).
17. Brown GW and Harris TO. "Social Origins of Depression: A Study of Psychiatric Disorder in Women". London: Tavistock Publications (1978).
18. Stern D. "The Present Moment in Psychotherapy and Everyday Life". New York: W and W Norton (2004).
19. Beebe B., *et al.* "The origins of 12-month attachment: a microanalysis of 4-month mother-infant interaction". *Attachment and Human Development* 12.1-2 (2010): 3-141.
20. Tronick EZ. "Emotions and Emotional Communication in Infants". *American Psychologist* 44.2 (1989): 112-119.
21. Tronick EZ., *et al.* "Multiple caretaking in the context of human evolution: Why don't the Efe know the Western prescription to child-care?" In M. Reite and T. Field (Eds.) *The psychobiology of attachment and separation*. San Diego: Academic Press (1985): 293-321.
22. Tronick EZ and Weinberg MK. "Depressed mothers and infants: failure to form dyadic states of consciousness". In: Murray LCP editor(s). *Post-Partum Depression and Child Development*. New York: Guilford (1997): 54-85.
23. Sroufe LA. "Emotional Development: The Organization of Emotional Life in the Early Years". Cambridge: Cambridge University Press (1997).
24. Brazelton TB and Cramer BG. "The Earliest Relationship: Parents, Infants and The Drama of Early Attachment". London: Karnac (1991): 15.
25. Stern D. "The Interpersonal World of the Infant: A View from Psychoanalysis and Developmental Psychology". New York: Basic Books (1985): 148.
26. Stern D. "The Motherhood Constellation: A Unified View of Parent-Infant Psychotherapy". London: Karnac (1995).

27. Bowlby J. "Attachment and loss, Volume 1: Attachment. New York: Basic Books (1969).
28. Fonagy P and Target M. "Attachment and reflective function: Their role in self-organization". *Development and Psychopathology* 9.4 (1997): 679-700.
29. Schore AN. "Affect Regulation and the Origin of The Self". Mahwah, NJ: Lawrence Erlbaum Associates (1994).
30. Schore AN. "Attachment and the Regulation of the Right Brain". *Attachment and Human Development* 2.1 (2000): 23-47.
31. Schore AN. "Effects of a Secure Attachment Relationship on Right Brain Development, Affect Regulation, and Infant mental". *Infant mental Health Journal* 22.1-2 (2001): 7-66.
32. Schore AN. "Dysregulation of the Right Brain: A Fundamental Mechanism of Traumatic Attachment and the Psychopathogenesis of Posttraumatic Stress Disorder". *Australian and New Zealand Journal of Psychiatry* 36.1 (2002): 9-30.
33. Schore AN. "Attachment, Affect Regulation and the Developing Right Brain: Linking Developmental Neuroscience to Pediatrics". *Pediatrics in Review* 26.6 (2005): 204-211.
34. Schore AN. "Attachment Trauma and the Developing Right Brain: Origins of Pathological Association". In P.F. Dell and J.A. O'Neil (Eds.) *Dissociation and the Dissociative Disorders: DSM-V and Beyond*. New York: Routledge (2009): 107-141.
35. Schore AN. "Neurobiology of Attachment". In T. Baradon (Ed.) *Baradon, T., (2010) Relational trauma in Infancy*. East Sussex: Routledge. Chapter 2 (2010): 19-45.
36. Bria K., et al. "The incidence of postpartum depression in new fathers". *British Journal of Midwifery* 16.10 (2008): 664-668.
37. Bion WR. "A Theory of Thinking". In E. Bott Spillius (ed.) *Melanie Klein Today: Developments in theory and practice*. Volume 1: Mainly Theory. London: Routledge (1962a).
38. Bion WR. "Learning from Experience". London: Heinemann (1962b).
39. Winnicott DW. *Collected Papers: Through Paediatrics to Psycho-Analysis*. London: Tavistock Publications (1953): 7.
40. Winnicott DW. "The Child, the Family and the Outside World". London: Penguin (1964).
41. Winnicott DW. "The Transitional objects and transitional phenomena. Playing and Reality". Hove and New York: Brunner-Routledge (1971).
42. Winnicott DW. "The use of an object and relating through identifications. Playing and Reality". Hove and New York: Brunner-Routledge (1971a).
43. Winnicott DW. "Mirror role of mother and family in child development. Playing and Reality". Hove and New York: Brunner-Routledge (1971b): 3.
44. Boukydis CFZ. "Collaborative Consultation With Parents and Infants In the Perinatal Period". Maryland: Paul, H. Brookes Publishing Company (2012).
45. Boukydis CFZ. "Support for Parents and Infants. A Manual for Parenting Organizations and Professionals". Boston MA: Routledge and Kegan Paul (1986).
46. Boukydis CFZ. "Research on Support for Parents and Infants in the Postnatal Period". New York: Ablex (1987).
47. Boukydis CFZ. "New Directions in Reflective Practice. What can we reflect on?" *Infant Mental Health Journal* 31.6 (2010): 698.

48. Ravel S., *et al.* "Reward unpredictability inside and outside of a task context as a determinant of the responses of tonically active neurons in the monkey striatum". *Journal of Neuroscience* 21.15 (2001): 5730-5739.
49. Sroufe LA. "Early relationships and the development of children". *Infant Mental Health Journal* 21 (2000): 67-74.
50. Lieberman AF, *et al.* "Infant-Parent Psychotherapy: Core Concepts and Current Approaches". In Zeanah, C. H. Jr. Ed. *Handbook of Infant Mental Health 2nd Edition*. New York: The Guildford Press. (2005): 472-484.
51. Fraiberg S., *et al.* "Ghosts in the Nursery: A Psychoanalytic Approach to the Problems of Impaired Infant-Mother Relationships". *Journal of American Academy of Child and Adolescent Psychiatry* 14.3 (1975): 387-421.
52. Fraiberg S. "Clinical studies in Infant Mental Health". New York: Basic Books (1980).
53. Bowlby J. "Maternal care and mental health: A report prepared on behalf of the World Health Organization as a contribution to the United Nations program for the welfare of homeless children". *Journal of Consulting Psychology* (1951): 11-13.
54. Acquarone S. "Infant Parent Psychotherapy: A Handbook". London: Karnac (2004): 160-161.
55. Bowlby J. "Forty-four juvenile thieves: Their characters and home lives". *International Journal of Psychoanalysis* 25 (1944): 17-50.
56. Bowlby J. "Attachment and loss, Volume 2: Separation". New York: Basic Books (1973).
57. Bowlby J. "Attachment and loss, Volume 3: Loss, sadness and depression". New York: Basic Books (1980).
58. Bowlby J. "A Secure Base: parent-child attachment and healthy human development". New York: Basic Books and London: Routledge (1988).
59. National Mental Health Development Unit, "National Perinatal Mental Health Project Perinatal Mental Health of Black and Minority Ethnic Women: A Review of Current Service Provision in England, Scotland and Wales" (2011).
60. Baker-Shenk C. "Characteristics of Oppressed and Oppressor Peoples: Their Effect on the Interpreting Context". In M. McIntire (Ed.) *Interpreting: The Art of Cross-Cultural Mediation*. Proceedings of the Ninth National Convention of the Registry of Interpreters for the Deaf. Alexandria, VA: RID Publications (1986): 2.
61. Volterra V and Erting CJ. "From Gesture to Language in Hearing and Deaf Children". Washington: Gallaudet University Press Chapter 1 (1994): 9.
62. Karchmer M and Mitchell R. "Demographic and achievement characteristics of deaf and hard of hearing students". M Marschark and P Spencer (Eds.) *Oxford Handbook of Deaf Studies, Language and Education* (2003).
63. Schein J D. "At Home Among Strangers". Washington, DC: Gallaudet University Press (1989).
64. Sheridan M. "Inner Lives of Deaf Children: Interviews and Analysis". Washington, DC: Gallaudet University Press (2001): 19-20.
65. Parasnis. "Cultural and Language Diversity and the Deaf Experience". Cambridge: Cambridge University Press (1998).
66. Bowlby J., *et al.* "The effects of mother-child separation: A follow-up study". *British Journal of Medical Psychology* 29.3-4 (1956): 211-249.
67. Bowlby J. "The nature of the child's tie to his mother". *International Journal of Psychoanalysis* 39 (1958): 350-373.
68. Bowlby J. "Separation anxiety". *International Journal of Psycho-Analysts* XLI (1959): 1-25.

69. Bowlby J. "Grief and mourning in infancy and early childhood". *The Psychoanalytic Study of the Child* 15 (1960): 9-52.
70. Ainsworth MDS and Bowlby J. "An ethological approach to personality development". *American Psychologist* 46.4 (1991): 331-341.
71. Sansone A. "Mothers, Babies and Their Body Language". London: Karnac (2004): 71.
72. Sansone A. "Working with Parents and Infants. London: Karnac (2007).
73. Charura D and Stephen P. "Love and Therapy". Karnac: London (2015): 141.
74. Winter P. "Engaging Families in the Early Development Story. Neuroscience and Early Childhood Development: Summary of Selected Literature and Key Messages for parenting". Education Services Australia Ltd as the legal entity for the Ministerial Council for Education, Early Childhood Development and Youth Affairs (MCEECDYA) (2010): 4.
75. Cozolina L. "The Neuroscience of Human Relationships: Attachment and the Developing Social Brain". New York: W.W. Norton (2014).
76. Sabel V. "Starting Early". *The Green Parent Magazine*. (2016b): 23-24.
77. Hugman R. "Power in Caring Professions". London: Macmillan Press Ltd (1991).
78. Westergaard J. "Supervising the supervisor: transforming counseling practice". In Reid, H and Westergaard, and Effective Supervision for Counsellors. London: Learning Matters (2013): 176.
79. Sabel V. "Life After Delivery: A Phenomenological Enquiry into One Woman's Experience of Postnatal Depression". *European Journal for Qualitative Research in Psychotherapy* 5 (2011).
80. Smith JA., et al. "Interpretative Phenomenological Analysis". London: Sage (2009a).
81. Smith JA and Osborn M. "Interpretative phenomenological analysis". In J. A. Smith (Ed.). *Qualitative psychology: A practical guide to research methods*. USA: Sage. 2nd edition (2009b): 53-80.
82. Smith A. "Identity development during the transition to motherhood: An Interpretative Phenomenological Analysis". *Journal of Reproductive and Infant Psychology* 17.3 (1999): 281-299.
83. Smith JA and Eatough V. "Interpretative phenomenological analysis". In E. Lyons, and A. Coyle (Eds.) *Analysing qualitative data in psychology* London, United Kingdom: Sage (2007): 35-50.
84. Fitzgerald HE and Barton LR. "Infant mental health: Origins and emergence of an interdisciplinary field". *WAIMH handbook of infant mental health: Historical, cultural, and international perspectives on infant mental health* 1 (2000): 1.
85. Smith JA. "Beyond the divide between cognition and discourse: Using interpretative phenomenological analysis in health psychology". *Psychology and Health* 11.2 (1996): 261-271.
86. Crotty M. "The Foundations of Social Science Research". NSW: Allen and Unwin (1998): 9.
87. Markle D., et al. "Beyond Transcription: Technology, Change, and Refinement of Method". *Forum Qualitative Sozialforschung/Forum: Qualitative Social Research* 12.3 (2011).
88. Punch K. "Introduction to Social Research: Quantitative and Qualitative Approaches". London: Sage (1998).
89. Denscombe M. "The Good Research Guide: For Small-Scale Research Projects". Berkshire: Open University Press (2010).
90. Larkin M., et al. "Giving voice and making sense in interpretative phenomenological analysis". *Qualitative Research in Psychology* 3.2 (2006): 102-120.

91. Smith JA. "Reflecting on the development of interpretative phenomenological analysis and its contribution to qualitative research in psychology". *Qualitative Research In Psychology* 1.1 (2004): 39-54.
92. Willig C. "Introducing Qualitative Research in Psychology". Berkshire: Open University Press (2013): 99.
93. Smith JA. "We could be diving for pearls: the value of the gem in experiential qualitative psychology". *Qualitative Methods in Psychology Bulletin* 12 (2011a): 6-15.
94. Smith JA. "Evaluating the contribution of interpretative phenomenological analysis". *Health Psychology* 5.1 (2011b): 9-27.
95. Bowden C and Galindo-Gonzalez S. "Interviewing when you're not face-to-face: The use of email interviews in a phenomenological study". *International Journal of Doctoral Studies* 10 (2015): 79-92.
96. Fonagy P. "Prevention: the appropriate target of infant psychotherapy". *Infant Mental Health Journal* 19.2 (1998): 124-150.
97. Fonagy P. "Attachment theory and psychoanalysis". New York: Other Press (2001).
98. Fonagy P, et al. "Affect regulation, mentalization, and the development of the self". London, UK: Karnac Books (2002).
99. Speier D. "Strengthening Couple Relationships to Reduce The Risk of Perinatal Mood and Anxiety Disorders for Parents". *Journal of Health Visiting* 3.3 (2015): 160-165.
100. Sabel V. "The Blossom Method: the revolutionary way to communicate with your baby from birth". London: Vermilion (2012).
101. Krishbaum M and Olkin R. "Parents with Physical, Systemic, or Visual Disabilities". *Sexuality and Disability* 20.1 (2002): 65-80.
102. Papousek H and Papousek M. "Fragile Aspects of Early Social Integration". In L. Murray and P.J. Cooper (Eds.) *Postpartum Depression and Child Development*. New York: Guilford Press (1997): 35-53.
103. Chiron C, et al. "The Right Brain is Dominant in Human Infants". *Brain* 120.6 (1997): 1057-1065.
104. Flick U. "Introducing research methodology: a beginner's guide to doing a research project". London, United Kingdom: SAGE (2011).
105. Philipson IJ. "On the shoulders of women. The feminization of psychotherapy". New York, USA: The Guilford Press (1993).
106. Lago C. "Race, culture and counselling: The ongoing challenge". Maidenhead, United Kingdom: Open University Press (2006).
107. Ayers S, et al. "The effects of postnatal PTSD on women and their relationships: a qualitative study". *Psychology, Health and Medicine* 11.4 (2006): 389-398.
108. Bretherton I. "The Origins of Attachment Theory: John Bowlby and Mary Ainsworth". *Developmental Psychology* 28 (1992): 759.
109. Buist A, et al. "Recognition and Management of Perinatal Depression in General Practice". *Australian Family Physician* 34.9 (2005): 787-790.
110. "Conception to age 2: The Age of Opportunity". UK: Department of Health/Wave Trust (2012).
111. Frosh S. "Key Concepts in Psychoanalysis (2002)". London: The British Library (2002): 110.
112. Golding KS. "Nurturing Attachments: Supporting Children who are Fostered or Adopted. London and Philadelphia: Jessica Kingsley Publishers (2008): 111.
113. Guidance for Commissioners of Perinatal Mental Health Services. Joint Commissioning Panel for Mental Health: UK 2 (2012).

114. Liu C., *et al.* "Prenatal parental depression and preterm birth: a national cohort study". *British Journal of Obstetrics and Gynaecology* 123.12 (2016): 1973-1982.
115. O'Hara MW and Swain AM. "Rates and Risks of Postpartum Depression – A Meta-analysis". *International Review of Psychiatry* 8 (1996): 37-54.
116. "Reaching out: Involving Fathers in Maternity Care". The Royal College of Midwives (2011): 6.
117. WA Perinatal Mental Health Unit, Women's Health Clinical Care Unit, Women and Newborn Health Service. National Perinatal Depression Initiative: North Metropolitan Integrated Service Model Progress Evaluation. Perth, WA: Department of Health (2012).
118. Gordon Y. *Birth and Beyond*. Italy: Random House (2002): 300.
119. McNish H. "Nobody Told Me". London: Blackfriars (2016): 110.

Volume 5 Issue 4 September 2017

© All rights reserved by Vivien Sabel., *et al.*