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**Working with parental mental health problems in complex
parent-infant relationships:
a study on the power implications of approaches used in
infant services in Western Sweden**

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Erasmus Mundus Master's Programme in Social Work with Families and
Children

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I hereby declare that the Dissertation titled “Working with parental mental health problems in complex parent-infant relationships: a study on the power implications of approaches used in infant services in Western Sweden” submitted to the Erasmus Mundus Master’s Programme in Social Work with Families and Children:

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Abstract

Title: Working with parental mental health problems in complex parent-infant relationships: a study on the power implications of approaches used in infant services in Western Sweden

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In psychological, science and social research, infancy has been highlighted as a period of rapid cognitive, psychological and physical development in response to the environment the infant grows up in. In addition, these traditions of research have also emphasized how parental mental health problems can affect a parent's ability to meet their infant's needs. The approaches used in this practice area have not been analysed in the Swedish context considering their power implications to date. Following a qualitative research strategy, this thesis analysed descriptions of the approaches used in infant services work from the perspective of the workers. The four research questions focused on the descriptions of the circumstances around the families' attendance to the service, ideal parent-infant relationships, the approaches used, the challenges encountered and the power implications for the parent-infant and worker-parent relationships. Semi-structured interviewing in English and Swedish was used to gather the data and thematic analysis to analyse it. The data was analysed using attachment theory, the motherhood constellation, the social approach to mental distress, the four modes of power and the concepts of care and control in social work. The data was coded into 7 themes that revealed a strong link between structural disadvantage and individual problems in relation to parental mental health problems, an eclectic approach to social work practice in infant services, focusing both on the internal representations of and on the behaviours in relationships. The study also revealed the strong effect of the care and control tensions on relationship building between workers and parents, intervention and on the emotional well-being of both parents and workers. The underlying themes of social control elements in infant services were interpreted as an example of the risk rhetoric in social work, while infant services practices also demonstrated elements of intuitive social work knowledge production evident in flexible role perception and the promotion of bonding and bridging in infant group sessions. The study advocates for a stronger emphasis on power relations analysis, on reflection about risk and for a more active dialogue between practice and research in social work with families facing parental mental health problems.

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1. Introduction

1.1 Why should social work research study infant services approaches on parental mental health problems?

The parent-infant relationship has been a focus in medical, psychological and social knowledge due to its potential influence on a child's neurological, emotional and social development (Bowlby, 1958; Winnicott, 1988; Perry et al, 1995; Eagle, 1995; Tronick, 2014). Considering infants' vulnerability and dependence on their environment to develop their potential (Winnicott, 1988), studying the interventions that target hindering factors for good parenting is particularly important to foster good practice in the promotion of good development in infants. Parental mental health problems are considered one of the risk factors that can affect parenting, increasing the risk of childhood disorders, emotional developmental difficulties, child abuse and greater expression of distress in comparison with families where parental mental health problems are not present (Hall, 2004).

In response to this connection between disadvantaged environments and the propensity for social problems and compromised development, society seems to have breached the traditional expectation of only having the family as solely responsible for meeting the child's needs. The vulnerability of infants, their dependence on the environment to achieve their potential and discourses of universal service provision in Sweden have led to the creation of different family support services employing social workers to combat disadvantage (Kristiansen, 1998; Williams et al, 2008; Hogg, 2013; Statens Folkhälsoinstitut, 2013; Reinfeldt and Larsson, 2014). This policy direction has been informed by Sweden's status as a social democratic welfare regime with a high proportion of universal services and decommodification that would allow citizens from all classes to have access to the same opportunities (Esping-Andersen, 1990), as well as its child protection family-service orientation favouring prevention services (Svensson and Höjer, 2016). Studying the support system in place for infants, arguably the most vulnerable citizens in society, in a context of low decommodification and high proportion of universal services is a particularly important case as it can set an example for service provision in other regions.

Furthermore, service provision for infants of parents with mental health problems can be considered an example of the intersection between society and the nuclear family. Despite legislation protecting the rights of parents to form families, have privacy and self-determination (Council of Europe, 1950; United Nations, 1991), governments have chosen to intervene in family life to promote and safeguard children's development as a preventative measure against social problems and social risk (Weir, 2004; Reinfeldt and Larsson, 2014). Moreover, investment in early childhood through parenting supports has been theorized to promote equality across different classes in society, combat future intra-generational inequalities related to the ageing population trend and support the balance of family responsibilities across genders (Esping-Andersen, 2009). The intersection of both orientations in the legislation has created an inherent tension and power implications in this area of service provision (infant services), which has unfortunately not been analysed in depth in previous studies from a social work perspective. It is critical to examine the power implications in the worker-parent and parent-infant relationships to inform future practice, as the literature has highlighted that social workers are often in positions of power working with contexts of inequality and oppression, where they "need to exercise their judgement sensitively, and make

definitive decisions, with far-reaching implications for the lives of service users” (Smith, 2008).

1.1.1 Research problem

Previous studies on infant services have focused both on the experiences of families accessing infant services (Rosenström Domeij, 2010), or from the perspective of the professionals on the use of specific elements of infant services intervention (Norling Bergdahl, 2007; Malmquist Saracino, 2011) and on evaluations of the processes and outcomes achieved throughout it (Socialstyrelsen, 1993; Kristiansen, 1998, Skagerberg, 2010). However, these studies have used theoretical frameworks with a mainly psychological, biological or psychotherapeutic focus (e.g. theories on human social learning). The case of infant services work on parental mental health problems has not been approached from the perspective of the professionals taking into consideration the influences of the social world and power relations in the Swedish context yet. These perspectives can provide a novel reading on how professionals perceive parents with mental health problems accessing the service and the power relations implications of their work with them, which can be used to inform future policy and practice.

1.2 Aim of the thesis

The aim of this thesis is to describe and analyse the work in infant services with families facing challenges with mental health problems of different grades of severity and the resulting power implications, as described by professionals.

1.3 Research Questions

1. What processes do professionals believe cause attendance to infant services?
2. How do professionals characterize good parent-infant relationships?
3. How do infant services support good relationships between parents with mental health problems and their infants?
4. What are the challenges that parents and professionals encounter throughout the process of intervention and how do power implications influence the worker-parent and parent-infant relationships? How do professionals respond to these challenges?

1.4 Definitions of relevant terms in the thesis

After presenting the research questions, it is vital to ensure clarity in relation to the main concepts. For the purpose of this thesis, *infants* or *babies* will be understood as children from birth to 1 year of age, following the eligibility criteria of infant services. *Parents* or *service users* will refer to the children’s biological parents who are also their primary caregivers and have some type of mental health issue irrespective of the degree of severity. It is acknowledged that infants are also service users, but for the purpose of this thesis they won’t be included in this group when the term is used. Staff working in clinical positions in infant services with parents and infants are identified as *professionals*, *workers* or *practitioners*.

Child protection services will be referred to as *the social service*, following the direct translation of the Swedish original service name socialtjänsten. *Infant services* will encompass open ward services and closed ward institutions working solely with infants and their parents. The term *mental health problem* will be defined in the literature review below (see page 11). *Mobilization of power* will refer to an action where a social actor uses their influence through relationships to oppress or to enable new possibilities (Tew, 2006), this term will be defined further in the theoretical framework (see page 22).

1.5 The context of infant services in Sweden

This thesis is based on the perceptions of clinical staff working in infant services in Sweden. The following background will help frame the experiences described by the respondents.

The need for support for parents with mental health issues has been highlighted in different parts of the world including: Ethiopia, India, Vietnam, Peru, England and Sweden (Kristiansen, 1998; Harpham et al, 2005; Hogg, 2013). In the Swedish context, it was estimated that every year in Sweden up to 1998, 4% out of all families with an infant were in need of treatment due to infant-caregiver relationship challenges (Kristiansen, 1998).

In their work with parents facing mental health problems, specialist infant services have often focused on fostering a secure attachment, improving the child's development, the interactions in the dyad and the symptoms of the affecting mental health problems on the parent (Socialstyrelsen, 1993; Kristiansen, 1998; Norling Bergdahl, 2007; Clark, Tluczek and Brown, 2008; Smith, Cumming and Xeros-Constantinides, 2010; Rosenström Domeij, 2010). Studies on combinations of interventions on the parent-infant relationship in cases with parents with mental health problems, have linked eclectic approaches to improvements on the issues they focused on (Clark et al, 2008; Smith et al, 2010). The combination of one on one therapy with the mother, the infant and parent-infant therapeutic group work on mothers with depression has been associated with a decrease in self-reported depressive symptoms, baby's irritability and an improvement in the interactions in the dyad (Clark et al, 2008). Studies on other interventions including parallel mother and infant groups had similar effects on mothers with post-natal depression, with the added result of increases in cognitive and motor development in the infants (Smith et al, 2010).

In the Swedish context, service provision for infants and their families is divided between universal services that can be accessed by all citizens and targeted services that specialize on supporting specific groups (Reinfeldt and Larsson, 2014). Families in Sweden can generally access universal parenting support services in their intersection with a variety of issues ranging from the juvenile justice system to media consumption (ibid.). Families can access universal services for ante-natal and infant healthcare through the local Familjecentralen including midwifery services, infant health checks, often a social service liaison and an open day-care (ibid.). When parents have additional support needs, they can approach targeted services for ante-natal care and specialist infant services for parenting support. The majority of parents access the services in Swedish, but it has been documented that in some urban areas there are groups of non-Swedish speaking parents who access the services too (Socialstyrelsen, 1993).

Infant services in Sweden are specialist services that mostly work with infants younger than 1 year old and their parents using multi-disciplinary teams including social workers, psychologists, psychotherapists, nurses, special pre-school teachers and social educators

(socialpedagoger) (Socialstyrelsen, 1993). These services don't exist in every Swedish municipality and are funded by the state. Specialist infant services in the Gothenburg area are divided between open ward services (spädbarnsverksamheter) and closed ward institutions that provide in-patient services.

This research project will focus on the work of specialist infant services in the Gothenburg greater area. Three open ward services in the Gothenburg greater area participated in the research. These services provided group activities for parents and their infants 2-3 times a week in closed, small groups (about 6 families each time), so the services received the same participants every week. The families could be supported by the service throughout the child's first year of life. Families could self-refer to these services, but referrals from the social service are often prioritized. Other services like midwives from mother-infant healthcare, drug and alcohol services or mental health services could also make referrals. In addition to the group activities, the services also provided one on one support to organize further referrals and provide personalized support as needed. One closed ward institution in the greater Gothenburg area participated in the research. The institution performed parenting assessments during social service investigations, provided therapeutic placements for parents and infants in need of support and follow-up services in the community. It had the capacity to provide accommodation for up to 8 families and the average length of stay was 8 weeks.

These services work within a political context where the Swedish government has taken interest in the service provision for infants in families with difficulties in recent years under the rhetoric of attachment theory, preventative work against social problems and children's rights (Reinfeldt and Larsson, 2014). Parenting support has been recognized as a joint responsibility for the three tiers of government in Sweden: the municipalities, the county governments and the Swedish government (ibid.). The *National Strategy for the Development of Parenting Support – A Win for All 2009* highlighted the importance for the development of supportive and preventative services for parents facing difficulties (ibid.). Under the Social Service Act (*socialtjänstlagen*) and the Care of the Young Services Act (*lagen om vård av unga skyldigheter*), it is the responsibility of the municipalities to provide parents with support such as family counselling, mediation, custody agreements and the social service (ibid.). Secondly, both the county councils and the municipalities are responsible for maternal and child health services, as well as for providing parenting education around the time of the birth (ibid.). Finally, having ratified the United Nations Convention on the Rights of the Child, the Swedish government has committed to enforcing the child's right to live in a safe environment by providing information about child health and support for parents to use this information (United Nations, 1990; ibid.).

1.6 Structure of the thesis

After presenting an introduction on the importance of the research topic and the research questions, now we turn to presenting the definitions of mental health problems and previous research on this topic in chapter 2. Next, some approaches to assessing the quality of these relationships and a mention of the common approaches in infant services will be put forward.

Chapter 3 explains the theoretical framework including 3 theoretical points of departure that will be used for the analysis of the data collected. Chapter 4 will present the methodology and research techniques for sampling, data collection and analysis in the thesis, as well as putting forward the relevant ethical considerations.

The discussion and results section has been divided into 3 chapters. Chapter 5 presents the results in relation to the first two research questions under the themes of the reasons behind parents' attendance to infant services and how ideal parent-infant relationships are characterized. Chapter 6 identifies the clinical experiences in infant services work under the themes of the parent's lack of trust, the connection between the parent's internal experience and behaviours, and difficult parent-infant communication patterns. Chapter 7 will focus on the conflicting responsibilities for infant services workers and the emotional demands of these experiences on the workers.

The final chapter, chapter 8, will include a summary of the results and initial discussion in relation to the research questions, implications for social work practice, a reflection on the limitations of the study and recommendations for future practice and research.

2. Literature review - the relationship between parents with mental health problems and their infants

This literature review will introduce first the definition of mental health problems from the perspective of the bio-medical model and discuss the prevalence of parental mental health problems in the international and the Swedish contexts. Then, previous research on the effects of parental mental health problems will be presented focusing first on the effects on the parent's physical health under the bio-medical model and on the parent's thinking and behaviour through the perspective of psychology research. Neurobiological research will also be put forward to present the connection on the potential effects to the child's development. Finally, research with a psycho-social focus and personal accounts of mental health problems experiences will be used to present the potential effects for the family.

2.1 Definition of mental health problems

The definition of mental health problems is a highly sensitive issue due to the stigma associated to terms like mental illness and mental disorder from the biomedical and biopsychosocial models, which highlights the existing power imbalances in this area (Sheehan, Nieweglowski and Corrigan, 2017). Nonetheless, this term needs to be defined with the support of these sensitive concepts to be able to understand the topic of this report.

Mental disorders are defined by the World Health Organization (2017a) as experiences that include a mix of "abnormal thoughts, perceptions, emotions, behaviours and relationships with others". The American Psychiatric Association (2015) which publishes the Diagnostic and Statistical Manual of Mental Disorders 5th edition (DSM-V) used in most mental health service provision, reframes the character of these thoughts, emotions and behaviours as "significant changes". This definition also considers these changes as involving a dimension of emotional suffering and compromising the person's functioning in the main aspects of their life (ibid.). In contrast to this, *mental health* is defined as "a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community" (World Health Organization, 2014). The American Psychiatric Association (2015) adds to the above definition the importance of being able to engage in "healthy relationships" and to "adapt to change and cope with adversity".

Considering *mental health* and *mental illness* or *disorder* as opposite poles in a continuum (Beyondblue, 2016), *mental health problems* can be situated in between these two poles and affecting thinking, mood and behaviour, caused by a combination of "biological factors such as genes or brain chemistry, life experiences such as trauma or abuse [and/or] family history of mental health problems" (U.S. Department of Health and Human Resources, 2017). Given most of the studies used in the literature review used originally the terms *mental illness* or *disorder*, these terms will be used when necessary to present the results of those studies. However, the terms *mental health problems* and *mental distress* (see page 22 for definition) will be used to state their relevance to this study and present the findings and discussion of this study.

2.2 Prevalence of parental mental health problems

In the global context, the World Health Organization (2017b) has estimated that 4.4% of the global population suffers of the most common mental illnesses: depressive disorders and anxiety disorders. Within these figures, it is considered that at least one third represents moderate to severe cases (ibid.). The estimated prevalence varies across different regions in the world, the African region having the highest estimated prevalence of depressive disorders around 5.5% and the Americas having the highest estimated prevalence of anxiety around 5.7% (ibid.). In Europe, 4.2% of the population is estimated to suffer from depressive disorders and 3.9% of anxiety disorders (ibid.).

More to the point, in England in 2011 and 2012, it was estimated that 150-300 per 1000 new mothers were affected by adjustment disorders and stress, 100-150 per 1000 new mothers by mild depressive illness or anxiety, 30 per 1000 new mothers by post-traumatic stress disorder, 30 per 1000 new mothers by severe depressive illness, 2 per 1000 by persistent mental illness and 2 per 1000 new mothers by postpartum psychosis (Joint Commissioning Panel for Mental Health 2012; Hogg, 2013). In the Swedish context, in 2013 a study found that 5.7% of all children born in Sweden between 1987 and 1989 had at least one parent affected by mental health problems to the point of needing hospital admission while the children were under the age of 18 (Hjern and Manhica, 2013). Furthermore, at least one third of these parents had their first hospital admission due to mental health problems, whilst the children were aged between 0 and 5 years (ibid.). It is estimated that 100 to 200 infants in Sweden are born to mothers with post-partum psychosis and 8000 to 15 000 infants to mothers with severe depression every year (Karlsson, 2012).

2.3 Effects of parental mental health problems

Mental illness can affect parents as a pre-existing condition to the infant's birth that can worsen, reoccur or can appear for the first time after the birth as a result of physiological, environmental and emotional changes in the parent's life (Hogg, 2013). Mental illness can cause emotional distress and experiences that hinder a person's ability to follow-up on their physical health or that of their baby, or that lead them to engage in behaviours that put their health at risk (Priest and Barnett, 2008). For example, mental illness can affect an expecting mother's ability to attend ante-natal care to keep track of her own health, decrease the likelihood of breast-feeding in the future, increase the risk of sleeping difficulties, the engagement in high-risk behaviours, or cigarette and substance-use (ibid.).

The literature has also reviewed how certain parental mental illnesses can affect how parents process their thoughts, feelings and their behaviours in relationships (Hall, 2004; Seeman and Göpfert, 2004; Downing et al, 2014). Typical problems affecting parents with mental illness relate to them usually having a lot of thoughts and emotions to process including their own thinking, experiences of the symptoms of mental illness and their own emotions and thoughts about these symptoms (Downing et al, 2014). This flow of information can take over their cognitive resources, stalling the processing of extra information, leading to a lack of cognitive availability for the child and difficulties with taking in interpersonal cues (ibid.). For example, certain mental illnesses can cause unpredictable mood changes, bizarre behaviours, magical thinking, decreased capacity to deal with frustration, which in turn can affect the consistency of daily parenting routines (Seeman and Göpfert, 2004). Other affective symptoms influence the perceptions that parents can have of themselves (e.g. low self-esteem) and their consequent perception of their own children (e.g. children viewed as a burden or as saviours)

(Skerfving, 2015). The secondary effects of mental illness medications can also compromise a parent's ability to notice and respond to a child's cues (Seeman and Göpfert, 2004). Moreover, parental mental health problems do not just affect the level of parental response, but also the quality of stimuli parents can provide considering their role as frames of reference for the child's experience of reality (Skerfving, 2015). In her study interviewing older children of parents with mental health problems, Skerfving (2015) highlighted that when children are in the care of these parents, they can feel caught up in situations that are incomprehensible and scary for them (e.g. facing magical thinking).

This preoccupation with the level and quality of stimuli provided to infants in parent-infant relationships is based on neurobiological research that highlights how the brain works in a user-dependant way (Perry et al, 1995; Stern, 1995; Siegel, 2007). This means that stimuli are processed by the brain forming representations of the environment, which are reinforced by continued interactions with it (Perry et al, 1995; Stern, 1995). Infancy is identified as having many of the sensitive periods where early human brain development can be easily influenced by experiences with the environment (Perry et al, 1995). This highlights the brain's ability to adjust to the person's needs in their environment. However, given the more complex brain structures evolve from the base structures, certain paths of development in infancy can affect the way the brain functions later in life (ibid.).

In the case of infants, early inter-relational experiences are considered to affect the way in which other relationships will be developed in the future (Tronick, 2014). The characteristics of the interactions with others can affect an infant's affect, their ability to explore their environment in a positive way and to develop emotional empathy and closeness in later relationships (ibid.). This is due to infants using a process called *blind selection of information* to choose learning the ways of being that in the short term will provide them with the most growth, even if these patterns might prove damaging or inappropriate in their long-term development (ibid.).

Using dynamic systems theory, Tronick (2004) explains that infants create their frameworks for ways of being with others and for the meaning-making of experiences based on how their interactions with the environment support either the acquisition of meaning-making information (*expansion*) or the lack of growth in the amount of meaning-making information (*dissipation*). Positive interactions with significant people in the infant's life, give the infant an opportunity to build coherence amongst the meaning-making information amassed and to build on the complexity of this information (ibid.). The result is that the infant experiences positive feelings, seeks more information and feels connected to these caregivers, fostering adaptable and resourceful ways of being and meaning making (ibid). This process can be linked to the category of *secure attachment* coined by Mary Ainsworth, which refers to infants that have received emotionally sensitive care by their primary caregivers, feel comfortable exploring their environment and return to their caregiver for comfort when needed (Karlsson, 2012).

In contrast to the process of expansion aligned with the secure attachment category, interactions that fail to provide meaning-making information lead to a decrease in complexity and coherence (*entropy*) (Tronick, 2014). The sense of failure to gather more meaning-making information can cause the infant to experience anxiety, fear, loneliness and to attempt withdrawal (ibid.). This in turn fosters defensive, dissociative ways of being and meaning making, as the infant wants to preserve the remaining coherence in the rigid meaning making framework that is left (ibid.). The categories of *disorganized* and *insecure attachments* by Mary Ainsworth are used to describe infants that as a result of similar processes of entropy or exposure to frightening experiences, avoid demonstrating their emotional needs, demonstrate

them in high emotional tones or through contradictory cues (Karlsson, 2012). These categories of attachment have been linked to difficulties in balancing independence and dependence in later relationships (ibid.).

As previously discussed, mental health problems can get in the way of a parent's ability to provide their infant with sensitive interactions (Körner, 2005). Interactions that are responsive to the infant's needs and cues are necessary to promote healthy emotional development in the context of an emotionally safe relationship or secure attachment (ibid.). This type of relationship has been linked to the development of the infant's abilities to process one's own feelings and to apply cognitive and emotional skills to respond to social situations (Fonagy et al, 1991; Fonagy et al, 1995). In a secure attachment relationship, a parent can filter stressful situations and provide emotional regulation for the infant (Priest and Barnett, 2008).

Considering the importance attributed to the parent-infant relationship as a supportive mechanism for brain development, for meaning-making and social engagement, the difficulties of parents with mental health problems to connect with their infants emotionally suggest a risk to the child's course of development (Stern, 1995; Murray et al, 1996). Observational studies have identified that parents with mental health problems can often act in intrusive ways or provide too little response to their baby's cues (Murray et al, 1996). The babies in these dyads can respond by either expressing themselves in loud emotional tones or in contained behaviours (Weinberg and Tronick, 1998), behaviours that can be linked to the descriptions of insecure attachment categories described above. On the other hand, care role reversal is identified as a common experience for children of parents with mental health problems (Skervfving, 2015). For infants, this could translate into attempts to animate their parent emotionally when faced with flat affect (Stern, 1995).

Certain symptoms of mental illness can cause a person to have a bias towards noticing specific types of interpersonal cues or misinterpreting these (Downing et al, 2014). This has been identified as *projection* and refers to interpreting somebody else's behaviour from a biased perspective imposing the own subconscious emotional conflicts onto the other, assuming these characteristics as the identities of the other (Klein, 1975; Newman, 2008). Projections are considered signs of the subconscious conflicts or difficult feelings that a person owns but might be trying to resolve by externalizing them (Klein, 1975). This bias can also take the form of a parent's decreased ability to understand other people's mental states and for some an increased pessimism about the own capacity for change (Downing et al, 2014). These issues have also been highlighted in the self-disclosed narratives of parental mental health problems (William and Cowling, 2008).

From a psycho-social perspective, families can also face high levels of stress due to the stigma associated with having a mental illness, which can lead to automatic negative perceptions of the parents' parenting capacity and breakdown of supportive relationships (Nicholson, Sweeney and Gellar, 1998; Seeman and Göpfert, 2004; Tew, 2011). Juggling parental responsibilities and the own mental health needs can also add to the extra pressure on parents (Nicholson et al, 1998). The literature has documented that parents with mental illness can have difficulties being acknowledged as unique individuals having a unique relationship with their child, which highlights an imbalance of power between them and persons in the welfare system (Blegen, Hummervoll and Severinsson, 2010). Parents with mental illness are often also faced with other social problems including exposure to violence, substance misuse, poverty and lack of social supports, which can bring them to the attention of the social service and lead to custody and separation issues (Seeman and Göpfert, 2004; ibid.). In that sense, social workers can be in a position to either support parents with mental health problems through these issues, or be the ones to make the decisions leading to custody or separation

issues, either limiting or promoting the access to resources and exercising power to limit or enable behaviours in service users (Smith, 2008).

Self-disclosed personal narratives from parents with mental health problems, point out that they are aware of the effects that these can have on their interactions with their children and that this in turn can affect their view of themselves (Williams and Cowling, 2008; Logan, 2013). Parents can also have feelings of regret as they see and reflect on how their children's development and relationships are affected by the parent's experiences of mental health problems (Williams and Cowling, 2008; Smith et al, 2010). Consequently, without accounting for mediating factors, infants, parents and the relationship between them can be affected by this situation.

In summary, the literature on parental mental health problems highlights its potential effects on the inner experience of the parent and their behaviours, the risk to the child's development when exposed to an invalidating relationship with the parent and the high sensitivity of these issues due to the stigma mental health problems carries.

2.4 How is the quality of parent-infant relationships assessed?

An approach to assess how a parent-infant relationship is meeting the child's needs is to consider the different dimensions of parenting. In the UK, many services working with parents follow the Framework for the Assessment of Children in Need and their Families as a guide to consider the effect of different social problems on many of the parenting dimensions (Department of Health et al, 2000). This framework includes the following parenting dimensions as the basis for good enough parenting: basic care, ensuring safety, emotional warmth, provision of stimulation, guidance and boundaries, and stability (ibid.). Basic care and emotional warmth refer to the ability to ensure the child's physical and emotional needs are fulfilled, while safety relates to protection from harm (ibid.). Stimulation includes the parent's responsibility to support the child's development by providing opportunities for the child to grow physically, cognitively and socially (ibid.). Guidance and boundaries focuses on the parenting behaviours that can support good emotional regulation in children and positive ways of being in society (ibid.). Stability focuses on the provision of a safe and predictable family environment that promotes a secure attachment (ibid.). Considering the introduction discussed above, mental health problems can affect any of these parenting dimensions, but it can influence every parent-infant relationship in a different way depending on their specific characteristics. This framework serves as a way of mapping the effects of the problem on the lives of the parents and children, and establishing some goals for interventions.

Parent-infant relationships can be affected by difficulties in different ways and to different degrees of severity depending on the mediating factors between the social problem and the child's experience. A mediating factor that has been studied in relation to secure attachment is *reflective functioning*. Reflective functioning is defined as the observable portrayal of "the parent's capacity to reflect on the current mental state of the child" (Fonagy et al, 1995, p. 269), and a "non-defensive willingness to [...] make meaning of feelings" (Slade, 2005, p. 271). Reflective functioning enables parents to understand their children as separate thinking beings and to "reflect back and contain" the children's mental states, supporting the children's developing emotional regulation (Fonagy et al 1995, p. 269). Another mediating factor promoting secure attachment is *maternal sensitivity*. Ainsworth, Bell and Stayton defined it as the capacity to read accurately the cues of one's own infant and to act appropriately in response (Shin, Park and Kim, 2006).

These abilities could be connected to the promotion of Tronick's (2014) process of *expansion* and Mary Ainsworth's *secure attachment* in parent-infant relationships (Karlsson, 2012), which were discussed previously (see page 13). In fact, high reflective functioning and secure attachment in the infant-caregiver relationship have been linked in studies assessing these characteristics through the *Strange Situation Experiment* and the *Adult Attachment Interview* procedure (Fonagy et al, 1991, Fonagy, 2000). Both of these procedures are used frequently in research to assess adult attachment and infant attachment (Karlsson, 2012). In the Strange Situation experiment, researchers note the reaction of an infant to a temporary separation from their primary caregiver (Karlsson, 2012). Four patterns of reactions or categories of attachment have been identified: *secure attachment*, *insecure ambivalent attachment*, *insecure avoidant attachment* and *disorganized attachment* (Karlsson, 2012). These categories will be discussed in further detail in the theoretical framework (see page 20). The Adult Attachment Interview on the other hand, focuses on the coherency of the parent's narrative about their own childhood, their relationships with their own caregivers and their representation of their relationship with their infant (ibid.). It analyses the narrative in the interview transcript to assess the parent's stance towards their own experience, whether they have unresolved conflicts with it and their ability to understand the subjectivity of experience (ibid.). The analysis can lead to one of four categories of adult attachment which in turn correspond to the 4 categories of attachment in infancy (ibid.).

Putting these concepts together, parents in secure attachment relationships with their infants, demonstrating reflective capacity, find it easier to identify and track back the reasons for their children's defensive behaviours to cope with uncomfortable feelings in a relationship (Fonagy et al, 1991). This type of interaction supports the development of the infant's reflective functioning later in life, which highlights the intergenerational dimension to the relationship between reflective functioning, attachment and emotional regulation (ibid.; Fonagy et al, 1995). Parenting assessments focused on reflective functioning, maternal sensitivity and attachment can also provide information about how adverse conditions like parental mental health problems affect parenting behaviours and can determine the goals for intervention.

To sum up, the effect of psycho-social problems can be mapped by assessing each parenting dimension including basic care, emotional care and ability to protect from harm. The assessment can be expanded by tracking mediating factors like attachment style, reflective functioning and maternal sensitivity.

2.5 The infant services' toolbox

In the following paragraphs some of the common approaches and concepts used in this area of practice will be presented, which will facilitate the understanding of the theoretical context of practice.

A common approach for initial assessment of the parent-infant relationship is the *assessment of interactions*, which involves the worker observing the ways in which parent and infant respond to each other in routine situations like feeding times and playing (Lindberg, 2000). Following attachment theory, the underlying assumption here is that in these interactions the parent modulates the different levels of stimulation provided to the infant, who then learns what to expect and creates their own responses or ways to cope with the stimulation provided, whether to expect it or avoid it (Stern and Bruschiweiler-Stern, 1998). Interactions are often clinically assessed at the level of *microevents*, which are minute common repetitive and concrete events in the everyday interactions between caregiver and infant that form a non-

verbal dialogue of expressing and responding to each other's cues such as: eye contact, facial expressions and oscillations in the tone of voice (Stern, 1995). This focus on describing the behaviours in interactions without immediately deriving psychological interpretations is identified as an *ethological reading of microevents* and is used to draw out the predictable patterns in interactions and assess a parent's level of responsiveness to the infant's cues (Stern, 1995). However, the accuracy of this assessment is dependent on the duration and setting of the observation and on the relationship with the observant (Lindberg, 2000). A combination of other assessment methods is often used to validate the results of an assessment of interactions. (ibid.).

An important concept to take into account in an ethological reading of microevents is *mentalization*, which is the ability to think about how we think and to understand the personal experience as subjective (Seligman, 2014). Mentalizing in relation to oneself assumes an ability to be aware of one's thoughts and feelings and to observe them from a different perspective, to understand where they come from and consider how one will respond to them (Karlsson, 2012). The same process is applied when one mentalizes about somebody else's experience and is a guiding concept for supporting the parent's ability to meet the child's emotional needs (ibid.).

If mismatches in the ways cues are responded to in the parent-infant dyad are identified, workers can draw the parent's attention to the cues verbally by *talking as the voice of the baby*. While the worker gives the baby's cues a voice, they can model a behaviour for the parent to imitate and attempt to talk aloud on behalf of the infant with the added benefit of verbalizing and normalizing feelings of inadequacy as a parent and the commonalities between parent and infant (ibid.). This approach has been linked to improvements in the reciprocity of parent-infant interactions and on maternal sensitivity in teenage mothers with psychosocial difficulties (Carter, Osofsky and Hann, 1991). The infants in that study became in turn less irritable and adjusted to a common routine (ibid.).

Pro-social modelling is also commonly used in many areas of social work practice to promote desirable behaviours (Trotter, 2014; Trotter, 2015). This approach is based on social learning theory, which explains the learning of behaviours through a mixture of copying behaviours from role-models and responding to positive and negative reinforcements (ibid.). In this approach, the worker tries to influence the behaviours of others by identifying the desirable behaviours, providing praise when they occur, demonstrating these behaviours in practice and challenging undesirable behaviours and comments that support these (ibid.). A vital element in this approach is the worker's ability to empathize with the service user's situation to build a working relationship that can influence successfully the service user's behavioural change (ibid.). Empathy is defined as "the ability to understand people from their frame of reference rather than your own" (Cormier, Nurious and Osborn, 2009, p. 74). Despite its claim to effectiveness, it must be considered that pro-social modelling is based on the worker's judgement to decide which behaviour will be deemed desirable and in what context (Trotter, 2015).

In that sense, *appropriate touch* can be considered a non-verbal way to reinforce a positive message or praise (Wilson, 1982). However, there is no consensus in the literature about whether the use of touch is beneficial for service users and if so when or why this would be (Kertay and Reviere, 1993; Strozier, Krizek and Sale, 2003). While some proponents of touch highlight its benefits as an equalizer, as a grounding technique and communicating emotional support, others warn of its implications in widening worker-service user power differentials and being used as a response to the worker's rather than the service user's needs (ibid.). Previous studies have brought to the fore the concerns of practitioners that touch could lead to

the service user's infantile regression in their behaviours or to the development of sexual feelings in the worker-service user relationship (Wilson, 1982; Strozier, Krizek and Sale, 2003).

Humour can be a useful tool when establishing the working relationship with families. Constructive humour was discussed by Trotter (ibid.) as a means to recognize the parent's experience of the encounter with the worker in a subtle way that is immediately responsive to the parent's comments. Integrating humour in the contacts with parents can be considered a delicate interpersonal skill, as demeaning, sarcastic or confusing humour towards the parent can be counterproductive to the establishment of trust (ibid.).

Marte Meo is another common approach closely related to social learning theory, it refers to the analysis of small video clips of everyday interactions between parents and infants, highlighting the best interactions that support the infant's development (Kristiansen, 1998). By zooming into behavioural vignettes and commenting on the videos, parents can increase their knowledge about their child's needs and consequently improve the interactions in the relationship (ibid.). Furthermore, the aim is to create parallel positive interpretations of the child's behaviours and to practice mentalizing on the child's mind state (Downing et al, 2014; Williams et al, 2008). Research on the effectiveness of *Marte Meo* has demonstrated the effects it can have on increasing maternal sensitivity with mothers facing depression and improving parent-infant interactions (Vik and Braten, 2009; Høivik et al, 2015). *Marte Meo* was also connected to improvements in infant social and emotional development in terms of self-regulation, compliance, adaptive functioning, autonomy, affect and interaction with others (Høivik et al, 2015).

In connection with these concepts, *mindfulness* is a common approach to promote internal coherency. Mindfulness is the ability to be aware in a non-judgemental way of one's experience in the present (Vieten and Astin, 2008). This method has its basis on meditative traditions and focuses on "developing the capacity to simply observe or witness changing mental and physiological states without necessarily trying to alter those states and achieve some desired state of mind" (ibid., p. 68). Mindfulness focuses intensely on the present experience as subjective and through this non-judgemental attention it allows people to have more agency over their actions and avoid reactivity, as it enhances the ability to identify early cues and consider more calmly the available options for responding to a situation (Roemer, Erisman and Orsillo, 2008). In that sense, it can help people to challenge a rigid way of interpreting situations and focusing only on certain cues, which can be a common experience across different mental health problems (ibid.). Various studies have supported the effectiveness of mindfulness in decreasing stress and anxiety in a variety of situations ranging from parents with anxiety and depressive diagnoses to chronic pain and severe mental health problems (Miller, Fletcher and Kabat-Zinn, 1995; Grossman et al, 2014).

3. Theoretical Framework

This part of the report focuses on explaining the main theories that will be used to analyse the data collected. The aim of the study and the research questions contained the key elements of interventions on parent-infant relationships, parents with mental health problems and the mobilizations of power. Therefore the theoretical framework needed to have three theoretical points of departure: parent-infant relationships, influences of the social world on mental health and power relations. Each theoretical issue will be discussed briefly and the accompanying theories' prospective role in the analysis will be highlighted.

3.1 Theoretical point of departure 1: Parent-infant relationships

Theories on parent-infant relationships are necessary in this study, as they help us analyse the reported effect of parental mental health problems on the infant and the logic behind the approaches to intervention. Parent-infant relationships will be considered from the viewpoint of Stern's (1995) *motherhood constellation* and Bowlby's (1969) *attachment theory*.

In the context of Western, post-industrial societies, where babies are desirable and a close connection between mother and baby is taken for granted in the family life, Stern (1995) theorized on the changes in thinking that occur in new mothers and identified four themes in the new patterns of thinking (*motherhood constellation*). Some of these themes represent challenges that the new parent has not been confronted with before and the way in which they are managed depends on the circumstances around the new parent (ibid.).

The *motherhood constellation* focuses on changes in four areas of the new parent's thinking: *life-growth*, *primary relatedness*, *supporting matrix theme* and *identity reorganisation* (ibid.). In the following paragraph, we will have a closer look at each of the areas of thinking.

The *life-growth* theme focuses on fears about the mother's inadequacies to support the survival and normal development of the child (ibid.). In the *primary relatedness* theme, the mother confronts her fears about the inadequacy of her emotional capacity to pass on knowledge about interpersonal skills in a non-verbal way to the infant (ibid.). The mother experiences both sides of an interaction by experiencing her own feelings and the perceived feelings of the baby in response to their interaction through empathy (ibid.). At the same time, the caring activities remind the mother of her own experiences of being parented as a baby and how she perceived her own mother would have experienced these events (ibid.). If these experiences were undermining, there is a risk that the parent's repressed emotions from these unresolved experiences or *ghosts in the nursery*, can be triggered again by interactions with their infant and cause a psychological identification with the abuser (Fraiberg, Aldeson and Shapiro, 1975). These dynamics hinder the parent's ability to mentally stay in the present and directly read the infant's cues, so they represent a threat to sensitive parenting in terms of primary relatedness (ibid.).

The third theme, the *supporting matrix* theme, refers to a network of experienced women who can shelter the mother from the demands of daily life and provide parenting knowledge (Stern, 1995). Finally, the *identity reorganization* theme, focuses on the need for the mother to shift her identity from a career, partnership orientation and from being a daughter to being a mother and focusing on her relationship with the baby (ibid.).

These four themes provide a framework to understand the developmental transition of parenting, good-enough parenting practices and the infant's needs, which will serve to

contextualize the descriptions of parenting and of approaches to intervention that are required to answer research questions 3 and 4.

Attachment theory is the second theory used to consider parent-infant relationships.

Attachment is defined as a strong and long-lasting emotional bond connecting one person to another, despite distance (Bowlby, 1969). Attachment behaviours develop naturally in infants as a survival mechanism for them to get their needs met by adults, given their complete dependency in the first few months (ibid.). By portraying behaviours such as crying, smiling, making eye contact and so on, the infant and their caregiver can naturally create a pattern of interactions leading to a bond and a relationship (ibid.).

From the perspective of the parent attachment implies two care roles: parents need to be both a *safe base* and a *safe haven* for the infant (ibid.). When feeling distressed or under threat, the child can display proximity-seeking behaviours to the primary caregiver, using them as a safe base (ibid.). However, infants also require some distance to explore their environment and to return to a trusting adult as a safe haven when they encounter something that upsets them (ibid.). Both types of behaviours need to be balanced in the parent-infant relationship and it is the specific combination of these that results in a specific attachment style (Karlsson, 2012; Seligman, 2014). In that sense, Winnicott (1988) highlights the importance of predictable and sensitive care to foster normal development in infants, as they have the capacity to adapt to the style of interactions provided by the parent even when this might compromise them reaching their potential later in life due to an inability to establish internal coherence.

In her research with infant attachment, Ainsworth identified 4 styles of attachment through the observation of infants' behaviours towards their mothers after a brief separation in the Strange Situation Experiment (Karlsson, 2012). Infants with a *secure attachment* often seek proximity to the person they are attached to when feeling upset, but are confident to explore their environment and engage with others when not feeling under threat (ibid.). This attachment style has been linked to predictable and sensitive care provision, and has been proved to support normal brain development (ibid.).

The second category, *insecure avoidant attachment*, refers to infants that don't seek proximity to the attachment figure and avoid showing their need for a safe base (ibid.). This is understood as the infant's adaptation to a caregiver that does not respond to proximity-seeking behaviours (ibid.). In the third attachment style, infants with an *insecure ambivalent attachment* show a mixture of repressing proximity-seeking behaviours and displaying them to full emotional volume to achieve emotional closeness (ibid.). This style has been related to unpredictable caregiving, where the caregiver oscillates erratically between responding to and ignoring the infant's proximity-seeking behaviours (ibid.). These two styles of attachment have detrimental consequences for the child's sense of agency in their environment and their self-esteem (ibid.).

Considering the potential consequences in brain function, neurobiological research has put forward that the left hemisphere of the brain is responsible for the processing of rational thinking, while the right hemisphere focuses on sensations, feelings and non-verbal impressions (Siegel and Hartzell, 2004). Adults with an insecure attachment experience often depend more on either the left or the right brain hemisphere for experience processing, causing the person to downplay the importance of relationships or become overwhelmed with emotions (ibid.). The proposed path to better internal coherence is through relationships and experiences that promote *bilateral integration* or the use of both hemispheres of the brain when processing stimuli (ibid.).

The final attachment style identified is *disorganised attachment*. This style is typical of relationships where the infant is both afraid of the caregiver but in need of their protection and

proximity (Karlsson, 2012). This inherent contradiction in the relationship causes emotional confusion and can either cause the infant to assume a *false self* to completely adapt to the caregiver's needs or to believe that others are incapable of meeting the infant's needs (ibid.). Studies estimate that 10-15% of children in Sweden develop a disorganised attachment (ibid.). Evidently, insecure and disorganized attachments create significant difficulties for the growing infant to live in society.

Considering the different types of attachment that an infant can develop in response to their environment, the daily interactions between infant and parent can build an *internal working model* for future interactions in life, which will shape the infant's expectation for future relationships (Bowlby, 1958; Eagle, 1995). The patterns created in the parent-infant relationship can be self-reinforcing, creating vicious or virtuous cycles of behaviours (Howe, 2005). Attachment theory is relevant for analysing parenting behaviours as well, as demonstrated in the *Adult Attachment Interview* procedure discussed previously. This analysis of the ways in which parents talk about their own childhood experiences can be aligned to one of four categories of adult attachment, which correspond to the four infant attachment styles (Siegel and Hartzell, 2004). The relevance of this method lies in the link that has been established between the modes of adult attachment to the attachment styles the children of these adults are likely to develop (ibid; Karlsson, 2012).

The theoretical positions on parent-infant relationships translate into practice in mainly two ways according to Brandt (2014): in the *implicit* and *explicit therapeutic planes* of an interaction. The former relates to the internal processes that underpin action including thoughts, feelings, beliefs, representations, memories and brain chemistry (ibid.). The latter refers to observable behaviours in the interactions (ibid.). Interventions on one plane often affect the other (ibid.). From the implicit plane, we reflect and choose between different possible actions in an interaction, and then we execute behaviours in the explicit plane (ibid.). The execution of these behaviours and the reactions from others can affect how we represent them in the implicit plane also (ibid.).

Attachment theory provides a framework to analyse the descriptions of parent-infant and worker-parent relationships provided in response to research questions 1-3. The distinction of implicit and explicit therapeutic planes will also be necessary to analyse the descriptions of approaches to answer research question 3.

3.2 Theoretical point of departure 2: influences of the social world

Given the study's aim to analyse infant services approaches in the work with parents with mental health problems of different degrees of severity and the resulting mobilization of power, a theory that encompassed diagnosed and undiagnosed mental health problems, and the power relations related to them was needed for the analysis.

In the mental health services system, the biomedical and the biopsychosocial models have become the first basis for the explanation of distressing mental health experiences (Slade, 2009). However, these models and their overreliance on biological explanations for mental health problems have been criticized for oppressing service users through stigma, categorizing experiences through subjective meaning-making and for reinforcing professional power by portraying professionals as having the power to "cure" service users (ibid.). The *social approach to mental distress* provides a framework to understand these experiences, their causes and consequences from a whole society perspective, rather than an individualized one

(Tew, 2011), which provides a less oppressive framework from which to analyse the power mobilization in these experiences.

This approach rests on the basis of three main values. It considers *mental distress* (mental health problems) within the spectrum of regular human experience in contrast to stigmatizing people with mental distress and labelling them as inherently different (Tew, 2005). Secondly, it accepts the interaction between the inner experience and behaviour of a person, and analyses all the fragmented and paradoxical dimensions of an experience together (ibid.). Finally, it rests on the recognition that people with mental distress create valid knowledge on their own experience which is attached to their understanding of the past and their hopes for the future (ibid.). This knowledge is expressed both through verbal communication and non-verbal behaviours that in another context might only be attributed to being symptoms of an illness (ibid.).

According to the social approach to mental distress, experiences of mental health problems can be interpreted as mental distress, protective mechanisms against previous adverse life experiences (Plumb, 2005; Tew, 2011). Otherwise, they can also be considered as “internalisation[s] or acting out of stressful social experiences” and the own personal signals of suffering due to oppressive life circumstances including abuse, loss and grief and trauma (Tew, 2005, p. 20). These mechanisms might be inappropriate for surviving in other contexts outside of the one they were developed in and cause detrimental effects for the person (ibid.). The connection between experiences of social disadvantage and mental distress has been recognized in mental health policy in some countries, as in the case of the National Service Framework for Mental Health in the UK (Department of Health, 1999).

Experiences of mental distress affect one’s functioning significantly at the emotional, social and mental level, limiting personal agency, a person’s “ability [to] organise [them]selves sufficiently in order to deal with [...] underlying unease or the ordinary expectation of [...] social and family lives” (Tew, 2011, p. 29). This can also refer to a person’s power negotiate the limits and character of their interpersonal relationships (Tew, 2005). Mental distress is also characterized by negative conceptions of personal identity and relationships, lack of possibilities to express the feelings they generate and lack of support (Tew, 2005 and 2011).

The social approach to mental distress also considers the social consequences of behaviours related to mental distress for people with these experiences. Tew (2011) puts forward that “any failure to deliver a sufficient appearance of coherent agency can lead to severe social sanctions”, referring to a breakdown in interpersonal relationships (p. 54). Goffman identified that society’s response to behaviours related to mental distress can contribute to a person’s stigmatisation, turning their representation “from a whole and usual person to a tainted, discounted one” (ibid. p. 3).

In the analysis of this study’s findings, the social approach to mental distress will provide a focus on the effect of the parent’s social experiences on their mental health and the implications for the approaches described by respondents.

3.3 Theoretical point of departure 3: power relations

The study’s aim made it a requirement to include in the theoretical framework a theory that could analyse the mobilization of power in the relationships between workers and parents, hence Tew’s (2006) theory on modes of power in relationships was chosen. This theory con-

conceptualizes *power* as being exchanged in relationships with the capability of oppressing or enabling new possibilities (ibid.). Tew (2006) considers four modes of power in relationships: *protective power*, *co-operative power*, *oppressive power* and *collusive power*. *Protective power* involves using power in relationships to foster the safety of vulnerable people and their opportunities to reach further development (ibid.). *Co-operative power* relates to power used in collective action to promote the common good and reciprocal support while respecting the different identities within the group (ibid.). *Oppressive power* refers to power used in a zero-sum way to establish dominance over others while taking advantage of the differences between different members of a group (ibid.). Finally, *collusive power* is used when a group takes collective action to oppress those who are considered different from the normative identity of the group (ibid.). The former two forms of power are considered productive modes of power, while the latter two are limiting modes of power (ibid.).

In that sense, some groups of service users can be considered to have less access to productive modes of power. For example, women are identified as a group subjected to a lesser access to resources and a lower status in comparison to men, and are in need of supportive connections and relationships amongst women that can provide validation (Williams, 2005). The structural reasons for this disadvantage lie in the dominant gender socialization, which oppresses women through messages of hostile and benevolent sexism that both men and women learn about as the normal social expectations (ibid.). Hostile sexism includes views that portray women as “irrational, incapable and incompetent” (ibid. p. 150). Benevolent sexism obscures men’s contribution to women’s oppression by constricting the role of women in society as inherently responsible for providing emotional warmth for others, even when these roles are depreciated (ibid.).

The dominant gender socialization discussed above can also affect normative expectations of which women are considered healthy or ‘sick’ (Williams, 2005). In that sense, women who behave in ways that are contrary to the dominant expectations of femininity in society, the internalization of feelings, are labelled as unhealthy (Plumb, 2005). This is exemplified in the fact that women are often socially sanctioned for externalizing anger, despite their higher likelihood of exposure to oppressive situations (ibid.).

Discussions of power relations are particularly relevant in the descriptions of social work practice as the narratives can reveal the construction of certain identities that confer or take away power from individuals (Margolin, 1997). In relation to this, the behaviours expected by society of a person in a specific situation, or their social role, are often constructed in the transactions with others (Day, 1981). Role definition is also affected by the person’s own expectations of how they should behave in their specific situation and the responses they get from significant people in that situation (ibid.). This reflection presupposes a continuous mutual negotiation of roles through relationships and consequences for the power individuals can access. This is particularly relevant for social workers, as depending on the context, the profession can either enforce behavioural rules favoured by society (*social control dimension*) or prioritize the person’s self-determination and their needs (*care dimension*) (Margolin, 1997; Okitikpi, 2011; Hardy, 2015). The former relies on an individual responsibility explanation for social problems while the later focuses on social explanations (Margolin, 1997; Hardy, 2015). The social control dimension can be related to the *risk discourse* due to its alignment with the values of individual freedom favoured by neoliberalism and cognitive and behavioural approaches (Hardy, 2005).

Having presented the three theoretical issues that will be used in the analysis, now we turn to the presentation of the methods used for data collection.

4. Methods

4.1 Methodology, research design and techniques

This part of the report focuses on presenting the rationale behind the methods chosen for data collection, sampling, as well as the limitations and challenges that were incurred with these choices.

This research is based on an interpretivist epistemology and a phenomenological philosophical approach, as it seeks to understand the social phenomenon of infant services practices from the viewpoint of the workers as social actors highlighting their perceived reality (Kvale, 1996; Bryman, 2016). It also relies on a constructionist ontology, which builds on the construction of social objects through the interactions between people (e.g. the interviewer and the respondents) and denies their neutral existence in the social world (ibid.). This is particularly important in this case, as the same issues might be described differently but with no less claim to reality by other social actors like parents with mental health problems or older children who were at some point infants in these services. Under these epistemology and ontology, it is recognized that alternative ‘truths’ about the same phenomenon can co-exist in the social world (Bryman, 2016).

The research questions focus on a broad perspective of the approaches used in infant services. Due to the need for rich descriptions to respond to the research questions, a qualitative method was chosen. In that sense, previous research on parenting support has highlighted that questions related to parenting can be difficult to answer thoroughly using quantitative approaches, as respondents need to reflect on the parent’s needs, the child’s needs and how these are prioritised in the parent’s behaviour (Neander and Mothanden, 2015). Given the study’s aim to describe and analyse infant services work with parental mental health problems and the novel focus of this study on the influences of the social world and power relations in this process, this study followed a combined exploratory and descriptive design (Marshall and Rossman, 2016). As other exploratory studies, this study is primarily inductive as it puts together concepts from existing theory in light of the results obtained, but also contains deductive elements as the literature review informed the research questions and interview guide (Stebbins, 2011). The research questions required discussing emotionally charged information about human relationships, so the chosen method needed to allow a confidential space and time, for the respondents to share their reflections freely. Therefore, interviewing was chosen as a better method to allow respondents to express their reflections at great length (Walliman, 2006).

The research technique was semi-structured interviewing. This approach was chosen due to the flexible order of questions arising spontaneously in response to the interaction with the participant, which allowed rich descriptions; and the comparability of data in the responses (Bryman, 2012). Given interviews on separate cases were made at a single period in time using the descriptions of infant services work as the units of analysis, this study followed a cross-sectional research design (Burke, 2004).

4.2 The process of literature review

The search for relevant literature on this topic was an ongoing process in both English and Swedish, and focused initially on searching in article databases through SuperSearch in the

UG library website, b-on and Google Scholar. The initial keywords used included “parental mental health problems AND infant”, “reflective functioning AND infant”, “emotional availability”. After reading every article, relevant authors and concepts in the bibliography were highlighted and cross-referenced by searching for articles in the online databases, for books in different libraries in Sweden through libris.kb.se and requesting the UG library to buy books that were not available. Published dissertations on similar topics were also sought through the UG library website. Additionally, websites on international non-government organizations and government bodies publishing research on this issue were also included in the search for political context information and current practices such as: the World Health Organisation, Socialstyrelsen, NSPCC, Socialdepartamentet, COPMI, etc. This process was self-reinforcing and continuous as new concepts and theories were highlighted at different points of the study. Due to the vast amount of literature available across different professional disciplines in this topic, all of it could not be included in this report. Preference was given to literature that seemed relevant to the results and social work, and as the theoretical framework started to be defined, then the search for literature was guided by it.

4.3 Sampling

Purposive sampling was the approach used for this research. Purposive sampling is a non-probability sampling approach where participants are chosen on the basis of criteria that the researcher deems as typical of a specific group (Walliman, 2006). The criteria to choose participants was current employment as a clinician in infant services with families; irrespective of age, profession, gender, or amount of years of professional experience. Clinical experience was a necessary criterion to acquire detailed and current information on the approaches and challenges of the work and due to the researcher’s choice to tackle the interviews as conversations about families the participants had worked with. No other eligibility criteria for participation was used in an attempt to capture the diversity of views within infant services. For this study, ten parenting support services in the Gothenburg greater area were contacted in the search for respondents via e-mail (see appendix 10.1). Out of these ten services, four were open ward specialist infant services and the rest were closed ward institutions, including a specialist infant service and 5 institutions for families with children of different ages. Six services responded to the contact but 2 declined participation. Nine respondents volunteered to participate from 4 infant specialist services, including 3 open ward services and 1 closed ward institution. The number of respondents was considered sufficient as the data reached a point of saturation, where respondents started repeating some of the content from the first few interviews in the study (Marshall and Rossman, 2016).

The majority of the respondents were social workers (6 out of 9), the remaining respondents were a clinical psychologist, a midwife and a certified nanny (barnskötare). The level of professional experience of the respondents ranged from 2 years to 45 years in their chosen profession. All respondents were Swedish and female. Only limited participants’ information is provided in the table below to protect the confidentiality of respondents.

4.3.1 Participant's biographical information

Pseudonym for participant	Type of service	Gender
R1	Open ward service	Female
R2	Open ward service	Female
R3	Open ward service	Female
R4	Open ward service	Female
R5	Open ward service	Female
R6	Open ward service	Female
R7	Closed ward institution	Female
R8	Closed ward institution	Female
R9	Open ward service	Female

4.4 Interviewing

The interviews were conducted by the author at the respondents' workplaces in interview rooms and were recorded with a digital recorder. The initial interview was a group interview with two respondents, the rest of the interviews were individual. The initial interview was the first interview for the author to conduct in Swedish and the group interview mode was chosen by the author and the participants to ensure that they could support each other to navigate the language difficulties. Both participants reported having worked together harmoniously for several years and presented as comfortable with the group interview arrangement at the time. However, it is acknowledged that a social desirability bias could have affected some of the content in their responses.

The duration of the interviews ranged from 27 minutes to 1 hour 10 minutes depending on the time the respondents had available. After the eighth interview, it was evident to the author that a point of saturation was being reached. The final ninth interview (27 minutes) was arranged to deepen understanding of a specific approach that had been mentioned in passing by other respondents, so only questions 2 and 3 and some of their sub-questions were used (see appendix 10.2 for interview guide).

The interview guide was originally devised in English and then translated into Swedish by the author and corrected with the support of a Swedish tutoring service. The interview guide was based on the aim of the study, the research questions, the literature review and the theoretical framework. The three main questions (1, 2 and 3) were derived from the research questions. Sub-questions on the referral processes, priority system for referrals and time management, consensus on the focus of the intervention and the relationship between workers and parents, were aimed at getting descriptions of the mobilization of power in the role of infant services following the aim of the study. Sub-questions 2.6 and 2.7 on the diversity of families and

workers aimed at broadening the perspective of the descriptions taking into consideration the diversity of cultural experience in families and of professional experience in infant services (see page 8). The final sub-question 3.9 attempted to obtain descriptions of the current signs of future challenges following research question 4.

The author conducted the interviews as a conversation about deidentified previous cases the participants had worked with and participants used these examples to answer most of the questions in the interview guide without the need to ask them. The author used the unanswered questions from the interview guide at the end of each response to probe further on unexplored dimensions of the examples. The interviews were conducted in either English or Swedish depending on whether the respondent felt comfortable speaking English during the interview or not¹. During the sampling process, it was highlighted by participants and gatekeepers of the service (workers who were contact persons), that it could be limiting for respondents to use English, especially when discussing clinical issues. Following Frost et al's (2015) strategies on conducting research using a second language, both the author and the participants constantly negotiated the meaning of the questions and answers by rephrasing what the other had said. In that context, 4 of the interviews were conducted in English, 3 in Swedish and in the remaining one both languages were used alternatively. As recommended by Frost et al (2015), a stance of reflexivity was taken while negotiating the main language for each interview, considering the fact that alternatively the researcher or the respondent could feel shame with a limited ability to portray verbally their professional identity when the questions referred to professional experiences.

The differences in the use of language could have caused differences in the context and atmosphere of the interviews. In that sense, Bury (2001) warned that at times participants' narratives can arise in response to the interaction with the interviewer, so they might not be generalizable even to other interactions in their lives. Hence, it is important to be aware that narratives are affected by the context they are produced in, and that they can change dynamically in response to critical interactions (ibid.). Nonetheless, as described above language issues were managed as best as possible choosing different interview modes when necessary, discussing the choice of main language with participants and using the expertise of the supervisor and tutoring service for further language support.

4.5 Validity, reliability and generalizability

Validity as defined by Mason refers to assessing whether the research strategies do measure what they were intending to in relation to the research question (Bryman, 2016). As evidenced in the strong link between the research questions and the interview guide (see appendix 10.2), this study seems to fulfil the criteria of validity.

Measuring this study against the criteria of external reliability by LeCompte and Goetz, this study could be replicated using the interview guide and following the sampling procedures outlined above, however it might be difficult to replicate the way in which both English and Swedish were used (Bryman, 2012).

In terms of external validity or the generalizability to other contexts (Bryman, 2012), due to the small number of participants and the reliance on convenience to do the sampling, this study cannot be categorically identified as generalizable of all infant services in Western Sweden. Nonetheless, after reviewing similar services in the literature (Socialstyrelsen, 1993;

¹ The author studied Swedish for 7 months prior to starting interviewing and speaks Swedish at a basic level.

Kristiansen, 1998; Rosenström Domeij, 2010; Skagerberg, 2010; Malmquist Saracino, 2011), the information provided by the respondents did not portray the participating services as a special case either.

4.6 Transcription and analysis

The interviews were transcribed manually by the author. Due to the author's limited knowledge of Swedish, the author consulted with two external native speakers on the transcription of specific passages. A mostly denaturalized transcription approach was used, which focused mainly on the words said throughout the interview, without noting the pauses or non-verbal actions, and using standard British English to correct diction or grammar that is part of non-majority English (Oliver, Serovich and Mason, 2005). These decisions were taken due to the research questions' focus on the content of the descriptions, so the way in which language was irrelevant in this context (*ibid.*). It was considered that this approach to transcription could widen the power differentials between participants and researcher, and could even misrepresent a cultural dimension present in the data. Nonetheless, the content of the responses was considered the primary consideration in the choice of the transcription method.

Thematic analysis was used to code the data, build themes and do the analysis. Thematic analysis refers to a process where transcripts are coded twice, then grouped into themes that are labelled and these themes are described in relationships to each other (Bryman, 2016). Following a process of categorization (Kvale, 1996), transcripts were coded by the author by summarizing the content of every quote into a phrase, which became the code and was stored in a table following the Framework method developed by the National Centre for Social Research (Bryman, 2016). The assignment of codes was based on the main meaning respondents wanted to convey and on the author's own experience of social work theory and practice. The table showed how the research questions were responded to in each interview. Using a process of continuous comparison and noting similarities and differences, codes were grouped into 16 themes that would answer the research questions and noted the possible relationships between these themes. This procedure followed Bryman's (2016) definition of a theme in thematic analysis, considering that the categories were drawn from the data in relation to the main focus of the research and that they were used to glean a theoretical understanding of it to contribute to further knowledge production.

On the other hand, it has been highlighted that a balance needs to exist between ensuring that coding and the building of themes are not solely dependent on the researcher's personal view, and allowing the complexity of meaning in the data to glean through (Kvale, 1996). This balance was worked on through group reflection between the author and the supervisor on the link between codes and themes, re-coding when necessary. Through this process, the initial 16 themes were grouped together into seven bigger themes. The first two themes related to the first two research questions directly: the professionals' perspectives on why parents attend infant services, and the professionals' characterizations of ideal parent-infant relationships. The last two research questions were answered in the five remaining themes. Three out of these five themes were related to the clinical experiences and the approaches proposed by the respondents: lack of trust and initiating worker-parent relationships, the connection between the parent's inner world and their behaviour, and difficult parent-infant communication patterns. The remaining two themes were grouped under the heading of the effect of the

practice context: conflicting responsibilities for infant services workers and the emotional demands of the work.

For the analysis, every quote in each theme was reviewed for its ability to represent a new dimension of the theme in a concise but descriptive manner, and their relevance was considered in light of the theoretical framework and other concepts from the literature following a process of interpretation (Kvale, 1996). For the purpose of this report, the relevant quotes and phrases in Swedish were translated by the author into English, the translations were confirmed by a Swedish tutoring service at the University of Gothenburg and the author's supervisor. The negotiation of meaning from the original transcripts to the translations was a triangular process between these three persons respecting the strengths of each, the command of both languages that the tutor and the supervisor had but also the author's knowledge of the quote within the lived experience of the interview (Frost et al, 2015).

Quotes were deidentified, but are traceable in the author's records through an anonymous identification system, all quotes have a code for the participant service (e.g. L1) and the respondent (e.g. R1).

4.7 Limitations

This study is not meant as an evaluation of the services provided and is not able to provide basis for a comparison between different locations either, as the sample size and the methodology were not thorough enough for these purposes. The data collected provides examples of strategic cases in this area of practice in the Western Swedish context.

Secondly, the limited possibility for data and method triangulation to confirm the results could be said to limit the validity of the study. Despite attempts to gain access to other approaches like observation, document analysis of case-notes and interviews with the families attending the services, it was not possible to gain access to other data due to confidentiality issues. This lack of access to the perspective of service users runs the risk of supporting the status quo of professional knowledge production being at the top of the knowledge hierarchy.

A third limitation to the research was the limited data acquired on the multi-cultural dimension of the research questions. Sweden is a multi-cultural society and some services are accessed on a regular basis by families from a non-Swedish ethnic background that might or might not speak Swedish or English. Evidently, this creates a different context for the intervention due to cultural differences and communication difficulties. This topic was discussed tangentially during the interviews, but was not explored through specific examples.

4.8 Ethical considerations

There is a great power differential between researchers and participants in research, all research must be analysed critically in terms of its consequences and implications as it can affect others in a multitude of ways. In that sense, these implications must be reflected upon throughout the project, as they affect every decision made by the researcher (Bryman, 2016). The research project was considered under 4 ethical points of discussion according to the ethical guidelines on research from Vetenskapsrådet (1990): transparency, self-determination, confidentiality and dissemination of information.

4.8.1 Transparency

Clear information about the aims of the study was provided to all participants verbally or in writing in either English or Swedish, depending on the person's preferred language. This was done to allow potential participants to consider the risk of harm for participating in the research and to enter participation with full knowledge of what it entailed (Vetenskapsrådet, 1990). All stages of the research were supervised by an academic supervisor from the University of Gothenburg.

4.8.2 Self-determination

Various authors and codes of ethics have highlighted the risk of harm to participants as one of the main themes in the discussion of ethical principles, especially in relation to confidentiality and informed consent (Vetenskapsrådet, 1990; Australian Association of Social Workers, 2010; Bryman, 2016). In relation to that, all respondents provided verbal consent for the interviews after being given a short explanation of the topics that would be discussed. They also signed a consent form in both English and Swedish ensuring the confidential handling of their details and the data, that the data would not be used for secondary analysis and that participation was completely voluntary. In line with recommendations on ethical research (Vetenskapsrådet, 1990), it was further highlighted that participants had the right to withdraw their consent at any time until the process of deidentification and transcription was initiated.

4.8.3 Confidentiality

In terms of confidentiality, the interviews were transcribed in a mostly denaturalized and anonymous manner, so that they could not be identified by others. On the other hand, respondents provided anonymized accounts of the stories of parents during the interviews and left out details that could identify the parents such as the outcome of the social service investigations.

The participant services were deidentified when writing this report and despite the reader's need to know the context of participants to understand the findings, a very limited participants' chart was provided to maintain confidentiality, given there are not many professionals who work in this area of practice and their identities could be otherwise tracked back easily through the intersection of their characteristics.

4.8.4 Dissemination of information

Ethical principles for social sciences research point that data should not be used for purposes unrelated to research without the consent of the participants (Vetenskapsrådet, 1990). This right was explained to participants in the consent form they. The data won't be used for any secondary analysis or other purposes outside of this thesis. Additionally, the author also plans to provide verbal or written summarized feedback to the organisations and the groups of parents that participate in the research, as recommended by the Australian Association of Social Workers' Code of Ethics (2010).

5. Results and discussion – setting the context

5.1 The professionals' perspectives on why parents attend infant services

This chapter focuses on the descriptions of the reasons for parents to attend infant services. The theme will be described through interesting quotes from the data, and discussed through the lens of the theoretical framework. A summary of the main findings for this theme and initial conclusions will be provided at the end of the chapter.

Respondents reported that the majority of service users in infant services had social problems that affected their interpersonal relationships and their family life.

So, to come to this treatment service, basically all parents who want to attend are welcome, but the parents that we focus on are those who have difficulties in their relationship with their infant. [The difficulties] can be [...] mental health problems, it can be a broken family life, it can be an unstable social situation. [...] [It can be] for example that women are physically abused, the father is in an institution, engaged in crime, and could... have... what... fled from war, could have so much trauma with themselves that forecasts detrimental effects in the family life. Brokenness in relationships. (own translation, R2, L1)

The respondent described a variety of social problems of different degrees of severity which compromised a person's ability to relate to others, including their infant, in a positive way. This description suggests a triple disadvantage for these parents: having to cope with the social problems, the lack of support due to the 'brokenness in relationships' and the difficulties of caring for a baby while having problems in their relationship. Respondents reported that these social problems could be episodic, chronic or develop into different problems over time. This characterization of disadvantage is aligned with the *social approach to mental distress*, which considers the trauma of the actual mental distress experience and the effect of stigmatization and risk of social isolation in response to the mental distress experience (Tew, 2011). Considering this triple disadvantage from the perspective of Stern's (1995) *motherhood constellation*, it can pose a threat to the completion of all four areas of thinking reorganization when becoming a mother: *life-growth*, *primary relatedness*, *supporting matrix* and *identity reorganisation*. The burden of the social problem and its effects can cause further anxiety for a parent aware of how their difficulties could affect their ability to fulfil the parental role in these four dimensions.

Respondents differentiated between parents who self-referred to the service and those who were referred by another service under recommendation or coercion. Parents that attended the infant services under self-referral, seemed to feel responsible for a deficiency in their relationship with their child:

[Most] of [...] the parents have more [a] feeling of [...] insecur[ity] [...] And so parents: 'Do I give my child enough? Why do[es]n't the child look at me so much? Is it because I'm bad, is it because I'm...the wrong things?' (R3, L2)

The respondent focused on an individual explanation of the problem and on the parent's belief of how their history and innate qualities might affect their ability to parent the child. The parent seemed to interpret the child's non-verbal cues as a realization of their own fear of not being able to support the relationship and of not being enough as a person. Of course, this self-doubt on the ability to foster the child's emotional development is often found in a lesser

intensity in most parents according to the motherhood constellation theory (Stern, 1995). However, the self-identified need for parenting support from infant services suggests that these doubts have behavioural consequences in the interactions with the infant.

From the perspective of Tew's (2011) *four modes of power*, the behaviours resulting from these self-doubts can be understood through the concept of self-efficacy. Self-efficacy is the belief in one's own capacity and right to influence their environment, having skills and resources to achieve this and being connected to others in a way that allows access to processes that challenge or develop power (Tew, 2011). When applied to parenting, it means that parents who have a firm belief in their parenting capacity are more likely to persist in their attempts to support the child despite difficulties in comparison to parents who don't believe in it (Newman, 2008).

Respondents also discussed how referrals from other services such as mental health services, drug and alcohol services and ante-natal healthcare services brought families to infant services. These referrals were often made due to concerns about how different social problems affected the parent's ability to provide basic physical care for the child, respond to the child's emotional needs appropriately or provide protection from harm.

Sometimes somebody else can perceive that there is a problem, that without knowing it, one is repeating something, a pattern, without being aware of the problem. (own translation, R2, L1)

The respondent described parents engaging in harmful behaviours as part of a vicious cycle that continued in their relationship to their infant. Connecting this statement to the previous description of disadvantage experienced by service users, the implied lack of awareness about the underlying problem in one's behaviours and its consequences for an infant creates an extra layer of disadvantage. The idea of an underlying pattern to a person's behaviours in relationships is consistent with the concept of an *internal working model*, which shapes the expectations for and the ways of being in relationships throughout a person's life (Bowlby 1958; Howe, 2005). This explanation relies on a linear model where the parent's past difficulties as an infant being parented are considered the cause of the current self-reinforcing pattern of disadvantage (ibid.). From a different perspective, under the *social approach to mental distress*, these patterns could become self-reinforcing due to the social isolation resulting from the stigma of mental distress, which can prevent the person from progressing towards recovery and changing their behaviours (Tew, 2011).

Given the multi-dimensional descriptions of disadvantage as the reason for attending infant services, respondents also discussed a structure in how referrals were acted upon, differentiating between referrals that were a recommendation and referrals that had an underlying compulsion:

We have a priority and it is first-time parents, people who become parents for the first time. Then we have prioritizing from our organisation, which means that we should first care... receive parents who have assistance from the social service, that is the social service comes here with them, [they are received] before those who come voluntarily. (own translation, R2, L1)

This respondent discussed a priority system based on the compulsion component in the social service referral and the parent's level of experience with parenting. The focus on the lack of parenting experience could be a sign of commitment to early intervention. On the other hand, prioritizing families who had been assessed by the social service as needing support to decrease the risk of harm to the child seems to follow a risk-management perspective.

Attempts to manage risk of harm and to intervene early in the life-course have been social policy directions linked to discourses of risk that promote personal responsibility to make socially acceptable choices (Kemshall, 2010). This approach to risk can miss the link with structural inequalities that undermine people's ability to make socially acceptable choices (ibid.). In that sense, respondents in this study attributed many different social problems as the reasons for referrals and focused on the individual disadvantage these produced.

Other referrals were discussed as triggered by a mismatch between the parent's social situation and the expected needs of the baby:

She has actually misused drugs for many years [...] and [...] one knew already and assumed that this baby could be born with drug withdrawals, which means that the baby has extra needs already from the start. [...] These two things are enough for the social service to start everything... to get concerned, so 'How is this mother with this mess in her baggage as we say, how will she handle this, how will she be able to look beyond this, her problems, to focus on responding to the baby's cues with all that it entails?' (own translation, R7, L4)

Here the respondent made a connection between the parent's past actions, their consequences for both parent and infant, and an assessment of future risk of harm to the child based on the expected mismatch between the child's needs and the mother's capacity. This assessment of risk in turn was taken as the rationale for a *social control* intervention by the social service. Using *protective power* in an attempt to protect the infant, the social service made a referral to infant services to support positive behavioural changes in the mother. Throughout the interview, the respondent reported that risk could be re-evaluated and that the mother could change her behaviours and her parenting capacity to match the child's needs with the support of services.

Having considered both internal and external processes that led to parents attending infant services, now it is relevant to highlight how they were described as a majority, returning to the theme of difficulty with relationships.

From that perspective, one of the major reasons for attending the service as reported by the participants was a lack of social supports:

All parents, I should say almost all of them [in this service], have disturbed relationships. So in that sense, they cannot handle close relationships with their parents, their siblings, their relatives or friends, because they have such big difficulties. Yes, it is very common that parents here are quite alone. (own translation, R8, L4)

The respondent discussed the social isolation of the service users due to their difficulties in relating to others, which seemed to be connected to their social problems. Framing this description under the *social approach to mental distress*, experiences of abuse and oppression can cause feelings of vulnerability, unassertiveness and shame that might make the person perceive relationships as risky (Plumb, 2005). Consequently, this might affect the person's ability to feel comfortable and maintain positive interpersonal relationships, which in turn increases their vulnerability and makes recovery more difficult (ibid.; Wallcraft, 2005).

Respondents also made a connection between the parent's mental health and the social problems they faced:

All parents that come here suffer from mental health problems more or less. In some cases it is evident in the fact that the parent has had documented contact with

psychiatric services. Yes, but [...] it is not always like that I think. [...] If one has such profound difficulties in their parenting like the majority of parents that come here, then one has mental health problems more or less. (own translation, R8, L4)

The respondent relayed the idea of mutual causality between the mental distress experiences of the parents and their parenting behaviours in the context of social problems. At the same time, she discussed that these experiences were not always identified or responded to by mental health services, which implied that infant services needed to assess parents through their engagement to identify if further assistance was needed.

Connecting this concept to the previous descriptions about dysfunction in relationships, this respondent described an example where a mother's previous experiences of multiple abuse by her partner had affected her own ability to engage in a working relationship with infant services:

We created a hypothesis that she was traumatised [...] which consequently made it difficult for her to... to trust that we wanted to do something good [for her] here. (own translation R8, L4)

The quote hinted at a link between the mother's previous experience and its potential effect on her ability to trust others in relationships. Considering the social approach to mental distress, abuse in intimate relationships relies on the abuser breaching the person's boundaries, diminishing their sense of control over interpersonal boundaries (Plumb, 2005).

Consequently, when a person has this experience they tend to seek security by relying on social behaviours at either extreme of the continuum between avoidance and emotional intrusiveness (ibid.). This is vital to understand the respondents' descriptions of parents who had difficulty trusting the services and engaged in different behaviours to avoid trust.

To summarize, the first theme focused on the reasons for the parents' attendance to the service, according to the professionals. The analysis showed that service users attended the services due to a mixture of internal and external processes, because either they or someone in the welfare system identified signs of disadvantage that could compromise their ability to provide for the infant's needs. The internal processes could be derived from a lack of self-efficacy, while in the external processes a risk assessment and the mobilization of protective power was involved. Overall, the descriptions focused on multi-layered disadvantage and were aligned with the social approach to mental distress. The descriptions suggested a strong link between social problems and the inability to engage in positive interpersonal relationships, which implied multiple disadvantage.

5.2 The professionals' characterizations of ideal parent-infant relationships

Having considered the starting point for the interventions in infant services, now we turn to discussing the intended goal of the interventions. This theme focuses on the positive descriptions of parent-infant relationships provided by the respondents. The theme will be presented through a mix of interesting quotes and comments by the author in connection with relevant literature.

Ideal parent-infant interactions were described as a constant verbal and non-verbal dialogue, fulfilling the emotional needs of both parties:

What I see is that [...] the child, his rhythm, his cues, so [...] the mother is there, that the mother responds, she follows up, she has fun with her baby, she loves her baby. But she also allows the baby to have some space to develop. [...] She talks, she puts into words what is happening – we work on this a lot, that the parent should explain what is going on. [...] The mother and I [...] share the joy over the child, [...] she shares stories about the child with me. And it is enormously important to have someone to share these things with. (own translation, R7, L4)

The respondent emphasized the importance of the parent being able to read the child's physical and emotional needs through their sleeping and eating routines; and through body language. The parent then responded to these signals by translating them into verbal communication and responding to the identified needs. This ability has been named in the literature as *maternal sensitivity*, which has been identified as promoting *secure attachments* (Shin et al, 2006).

Furthermore, for the respondent, the parent demonstrating her delight in her baby during their interactions and when talking about the baby, showed her love towards the infant. This description of meeting the child's physical and emotional needs can be aligned to the first two themes of the *motherhood constellation: the life-growth theme* and the *primary relatedness theme* (Stern, 1995). The literature portrays the ability of the mother to understand her infant's cues and respond sensitively to the baby's needs in the first stages after the birth as a natural development in becoming a mother (Winnicott, 1988). This quote also highlights the importance of predictability for the infant. Respondents advised that any attempts made by the parent to make their behaviour and the routines to meet the child's needs predictable contributed to the infant's feelings of emotional security. Predictability in the parent's responses to the infant allows the infant to integrate the different parts that will become the psychological self without intrusion from the environment before they are ready to cope with it, and to achieve developmental milestones in the natural order (ibid.).

The respondent also discussed the need for a balance between responding to the child's needs sensitively and allowing the child to grow independent slowly in the ideal parent-infant relationship. Considering attachment theory, this exemplifies the importance of parents being a *safe base* for the child to go back to when feeling under threat, as well as being a *safe haven* from which the child feels secure enough to explore the environment (Karlsson, 2012). This fine balance between these two behaviours supports spurts of growth where the infant can develop their capacity naturally and retreat from stimuli when it overwhelms them (Winnicott, 1988). The literature has recorded that the parent's ability to balance these two alternatives continues to be as important as the child grows older and similar base conflicts are faced in other arenas of life (Winnicott, 1988; Lindberg, 2000).

Respondents understood that the ability to read cues accurately and to balance the levels of stimulation the infant is exposed to, though desirable in parent-infant relationships, does not necessarily evolve overnight. Respondents shared stories of positive changes in parenting behaviours, where the parent went from acting anxious around the child's distress or exploration of the environment, to becoming comfortable in the parenting role:

You could see the spark between her and her daughter, you could see her falling in love with her daughter, enjoying her daughter, and seeing...her daughter's strength, and growth and development...and being happier. You could also see the depression...sort of melting. [...] And as she grew stronger, she didn't need us to take her, she said 'don't take her [...], I need to feel like I can do this, I can have this, I don't need help, even if it gets hard, I need to feel that I can go into a hard period and I

know that I am...we're gonna make it'. And she more wanted us to help her to focus on her daughter [...] and help her see what her daughter was developing and what she was reaching. (R4, L2)

The respondent described the intensification of the connection between parent and infant, translating into increased interest in the child as an individual, confidence in meeting the child's needs and physical closeness. These changes also influenced positively the mental distress experiences of the mother in a self-reinforcing virtuous cycle. Other respondents discussed similar stories where across time, parent and infant got to know each other better, which allowed the parent to become more comfortable in their role and to trust their child's capacity as they got to know them. These changes in behaviour seem to imply that parents had resolved the themes of *life-growth* and *primary relatedness* in the *motherhood constellation* (Stern, 1995). Some of the ideal behaviours identified by respondents could be interpreted as signs that parents had reconstructed their identity to fit the parental role, which in turn decreased their experiences of mental distress and provided motivation for further recovery. Some examples included the mutual rejoicing in the parent-infant interactions and the use of verbal communication and welcoming non-verbal communication, a combination that encouraged positive self-reinforcing communication patterns in the parent-infant dyad.

Respondents also discussed the importance of *reflective functioning* in ideal parent-infant relationships and characterized it as the parent's ability to see their infant's cues and understand their child's mental states without the hinder of other issues like mental distress or social problems. These descriptions were often accompanied by the assumption that parents had "fallen in love" with their infant, which presupposed a connection between the feeling and the cognitive ability to reflect on the baby as an individual. Stern and Bruschiweiler-Stern (1998) also write about the importance of this level of feeling for parents to be able to engage their reflective functioning on an ongoing basis in relation to the child and to provide for the child's emotional developmental needs.

In summary, respondents described the elements of love, mutual rejoicing and interest in getting to know the other as part of the ideal parent-infant relationships. These elements were identified through physical closeness, verbal communication and a developed ability to read the infant's cues. These abilities allowed parents to run predictable routines and to balance being a safe haven versus being a safe base for the infant, depending on their needs. Respondents also noted the self-reinforcing character of these positive interactions. The literature supports these descriptions of ideal parent-infant relationships as necessary for infants to achieve their potential and as a natural progression when becoming a new parent. This theme has shown the desired goal in infant services' interventions, the natural capacity of parent's and infants to influence each other positively in a cyclical way, and the importance of this relationship for infant development.

With the first two themes the context for the descriptions of infant services' work has been set. On the one hand, parents attending infant services have been presented by respondents as facing multiple layers of disadvantage leading to mental distress and disturbance in interpersonal relationships. On the other hand, the capacity for these parents to achieve nurturing, balanced and reciprocal relationships with their infants has also been portrayed as the desired outcome in the interventions. Now we turn to the descriptions of the clinical experiences and the approaches promoted by the respondents.

6. Results and discussion - clinical experiences

This chapter focuses on the clinical experiences that the respondents described in their work with families. The descriptions of clinical experiences and the approaches that the respondents described to tackle them were coded into 3 themes. Every theme will be described through a mix of quotes from the data, supported by the theoretical framework and relevant concepts from the literature. The descriptions of the themes will focus on the individual work modality first and then on the group work modality, if there was enough data on the later, which was not the case for all themes. Finally, the chapter will conclude with a brief summary of the findings and some preliminary conclusions.

6.1 Lack of trust and initiating working relationships

As mentioned in theme 5.1, respondents described the families they worked with as having survived through many social difficulties that caused their mistrust on services and difficulties to establish and maintain interpersonal relationships.

6.1.1 Lack of trust and approaches to gain it in the individual work modality

So I think that the primary issue, the absolute first thing one must work on is [...] to make the parent feel more or less secure in the relationship with me. Accordingly, I believe that if one is not successful at this, it doesn't matter which method one uses, because one still will not succeed. (own translation, R8, L4)

All respondents identified the importance of having a constant relationship of trust, full of respect, understanding and appropriate humour with the families to engage in the work. Furthermore, some respondents identified that the quality of the relationship developed with the parent was the basis for the success of an intervention in the family and that its effectiveness could not rely on the method chosen. Similar views have also been put forward in other infant services and in the literature, where the first task of the intervention was framed as developing the relationship with the parent and the service user's motivation for engagement (Kristiansen, 1998; Tew, 2001). This focus on the quality of the relationship could be related to the higher intensity of the intervention in comparison to other services for adults (Kristiansen, 1998), or the fact that the content of the intervention is likely to involve sensitive topics for the parents, which might not be possible to discuss without a well-established relationship.

Following this thought, some respondents focused on avoiding the direct exploitation of the position of authority they would have in normative parenting knowledge. Instead, they ceded some of the power for establishing the boundaries of the work to the parent, leaning more towards using *co-operative* instead of *oppressive power* to foster the parent's internal motivation. Considering the third theme from the motherhood constellation, *the support matrix*, this is particularly relevant in considering the establishment of worker-parent relationships (Stern, 1995). If the worker comes to be perceived of as a potential source of

social and practical support instead of a controlling figure, they could enrich the parents' support matrix if they manage to establish trust.

Different approaches to establish trust with families were discussed by the respondents, but all approaches implied an active effort initiated by the workers. Some respondents discussed establishing trust in their relationships with families through persistence in their attempts to establish contact.

The social service says in this case that she must have the infant service as a support measure, when she actually doesn't want it. I think many parents also want to handle things on their own. [...] I got to physically go to her and she wasn't there then, and I got to attempt it again and attempt it again until she... until we finally got a meeting arranged and she allowed that after a long time. She understands at any rate that I don't give up, that I wish her well. (own translation, R1, L1)

Persistence was understood in terms of demonstrating interest in the relationship with the parent and in continuing to attempt to make positive contact despite being turned down several times. Through an analysis of power in social work, Margolin (1997) has identified this approach with involuntary service users as *new aggressiveness*, where the social worker periodically reminds the service user of their availability to provide support despite constant rebuffs, until the service user identifies that they need the social worker and allows the contact to occur (ibid.). This image of a worker full of patience and unending capacity for accepting rejection can at times also obscure the investigative tasks that are part of *social control* elements in the role, as in this case the referral was related to an ongoing social service investigation (ibid.). As parents are also aware of some of these techniques, this makes establishing trust in a working relationship more difficult (Okitikpi, 2011).

From another perspective, the fact that the mother's wishes were in a way ignored through the action of the referral, could have made her more unwilling to connect with this worker for fear of having her decisions overturned again. Showing interest in the parent as an individual and making the parent comfortable in the conversations with the worker has been linked to better outcomes and outcome satisfaction for services users (Trotter, 2014). In this instance Bowlby's (1965) concept of the *internal working model* is quite relevant. Parents in these disadvantaged situations might have had experiences of unsatisfactory relationships where their needs were not met, they might have therefore learned to respond in an avoidant manner to attempts to make a connection. By giving the parent opportunities to engage in the relationship in an appropriate manner, the worker focuses on demonstrating a more positive pattern that encourages trust and challenges the old pattern.

Trust was discussed extensively by the respondents as an important basis for their relationships with parents. Respondents talked about a way into the relationship as a connection that enabled workers to have ongoing contact with the family, the family's commitment to the intervention and permission to discuss difficult matters. However, the work on the relationship was not limited to creating the initial connection, but needed to be continued to maintain trust with the parent. Respondents acknowledged the parents' underlying fear of being reported to the social service for concerns about their parenting as the main reason behind the mistrust towards infant services. This fear could be related to parent-infant separations due to a social service intervention, being labelled due to anti-social behaviour or having their identity as parents questioned.

Respondents described a way of initiating a good working relationship with parents using humour and respect. Here the focus of the method was on *how* the message of the worker's reliability was conveyed to the parent.

For me respect is the most important [thing]. To be able to say a number of difficult things. But humour is absolutely important, I must... we must be able to meet in the laughter I mean, in a respectful way, we won't laugh at each other but with each other. (own translation, R7, L4)

The use of humour and respect highlight the common humanity of both worker and parent, hinting at a common language in the relationship with the parent, where the boundaries of respect for the parent and an appropriate sense of complicity were held. This description of humour as a way to relieve a stressful situation and remind the parent of the commonality between parent and worker has been identified in the literature as *constructive humour* (Trotter, 2015). It also serves to subtly highlight the parent's perspective of the encounter with the worker (ibid.).

Other respondents created a sense of commonality with parents through the common interest in the child. From the bond between the parent and the child, another bond between the parent and the worker can develop based on the worker's display of concern for the child. Moreover, relating the intervention with the parent to the ordinary everyday situations of parenting and the non-verbal interactions is vital to support the parent-infant relationship, as it is through the everyday non-verbal family interactions that the infant experiences the relationship (Stern, 1995).

A different set of approaches to establish trust relied on workers and parents openly confronting an uncomfortable situation together to find trust at the end of the experience.

You talk about [the fact] that you understand that it is difficult... that you put into words what is difficult. [...] For example, that you say that it is very difficult to come here and accept help. I mean, to talk about it so that you can overcome the hurdle. (own translation, R2, L1)

In relation to this acknowledgement of the obstacles to the development of trust, relationships between the parents and workers need to enable the free expression of emotions, so that they can be used as an entry point to discuss the issues (Seligman, 2014). The respondent here implied normalizing the parent's fears and presenting an opportunity for the parent to explore how realistic these fears were by developing a connection with the worker. This approach can be understood as using empathy in relationships with service users. Empathy or accurate understanding, genuineness or congruence and positive regard or respect have been identified as the basic conditions necessary in the helping relationship (Cormier et al, 2009). Paraphrasing the service user's feelings and experiences, as shown in the example above, is a common technique to demonstrate empathy to service users (Trotter, 2015).

Respondents also conceptualized the process of establishing trust as a 'clearance process' guided by the parent, depending on the worker's response to the initial superficial contact allowed.

She had many, many problems. She [didn't] want us to start talking about her problems. She want[ed] us to talk about [...] what is good [in the] here and now. And one should start with that, I think. And so one gets to discover what is possible to talk about and what one can continue working with and so [on]. (own translation, R1, L1)

This quote exemplified that in some cases, the process towards trust relied on the worker sharing the power to lead the conversation and define the problem with the parent, to ensure they felt safe during the interaction. This seemed to allow the worker to start the work with the parent, an approach that has been recommended to create a collaborative alliance with service users (Trotter, 2014). Taking into consideration Tew's (2006) four modes of power,

this is an example of the mobilization of *co-operative power* to promote the family's well-being.

Respondents discussed an ongoing interactive process, where the worker negotiated boundaries with the parent, showing respect to these boundaries when possible and explaining the relevance of a topic when going beyond a boundary. This approach is aligned with the *social approach to mental distress*, where workers are encouraged to negotiate boundaries actively and display unconditional positive regard to avoid emulating abusive patterns (Plumb, 2005). This can represent an opportunity for the parent to get the positive emotional rewards of a respectful and positive relationship.

6.1.2 Group work modality approaches to create trust

The data on the group work modality in this theme was based on the descriptions of group infant sessions. The *supporting matrix theme* from the *motherhood constellation* takes a different perspective in the group work modality. Here, the social worker's role is not just to be part of the supporting matrix, but to facilitate other affirmative relationships that can also become part of the matrix. The workers partly attributed the development of these relationships to having established a relaxed atmosphere in the sessions:

We tried to have a relaxed atmosphere, we tried to be un-prestigious, and we tried to...be open. Sometimes it's good to just...make a fool of yourself, sometimes when we feel it's needed we can [---] offer the group your thoughts and mistakes. [---] And to be able to laugh about it. And take down the focus on prestige and accomplishing and greatness, and just be 'yeah we make mistakes and we are tired and sometimes we don't really think', just take it down a notch. (L2, R4)

Respondents discussed the use of both humour and self-disclosure to create an atmosphere with 'good-enough' expectations. As in the individual work modality, where communication through humour and respect was discussed, this method seemed to focus on highlighting the common humanity between workers and parents.

Respondents reported that affirmative relationships with peers seemed to develop in a context of structure and predictability facilitated by the way in which the groups were organized. Respondents described the difference between universal services that provided play groups in open groups and the closed groups in infant services.

It's a strength that's it's such a small group and that it's a fixed group. [...] That it's not open pre-school, where there might be 10 parents today and there might be 30 tomorrow. [---] And this, you can feel that 'oh but that's...that's Sofia, she knows me, she's this super 'control freak' and I can't, I don't need to fight with that, but I know she will find it funny, that I...that I put on the child's onesie backwards, or whatever I've done'. [...] We can laugh about it together, she has her things, I have my things, together we are a perfect person, but there is no such thing alone. (R4, L2)

Several respondents focused on how closed membership and the small size of the group could provide a sense of predictability for participants, as they could rely on previous interaction patterns with peers. There was also an underlying theme of companionship based on the daily struggles of parenting and unconditional acceptance amongst peers. Furthermore, the literature has highlighted the importance of structure in infant-parent groups to provide a sense of safety for both mothers and infants through predictability (Rosenström Domeij, 2010; Smith et al, 2010).

In relation to the benefits of group participation in this setting, by establishing new social ties with others and gaining membership to a group, a person with mental distress can obtain information on pro-social and pro-health behaviours through the group norms (Kawachi and Berkman, 2001). The person can also change their behaviour by identifying with the members of the group and imitating the desired behaviours (Feldman, 1981; Kawachi and Berkman, 2001; Smith et al, 2010). Motivation to engage in positive self-care behaviours can be gained through a sense of belonging, validation, emotional safety and sense of purpose in the group (Cohen, Underwood and Gottlieb, 2000).

Throughout the interviews, the sense of validation transmitted amongst group members was exemplified through the acknowledgment of the common developmental challenges of parenting. The literature has highlighted similar experiences of parents receiving support and validation for the daily struggles of parenting from their peers in group settings (Feldman, 1981; Williams and Cowling, 2008). Social workers have an important role in providing supported environments for service users to access affirmative social relationships that can increase their access to *co-operative power* through shared information, skills and resources (Tew, 2011). Through these affirmative relationships of mutual support, the service user's role can change to being in a mutually contributing relationship, supporting the increase of their peers' self-efficacy (Feldman, 1981; Tew, 2011). This is particularly important in the case of people who have faced coercive and socially isolating interventions that could have eroded some of their relationships and affected negatively their access to social support (Webber, 2005).

However, the sense of intimacy and mutual support could be limited to discussing the common developmental challenges of parenthood as in the previous quote or it could extend to talking about complex social problems depending on the members of the group.

We talk about everything from baby puke and...to... fathers who abuse. (R6, L3)

The respondent expanded this statement by describing how the mothers in her infant group responded to another mother disclosing childhood sexual abuse experiences during a group session. The description of this group revealed a strong membership identity where difficult topics were discussed openly and social support was sought and shared among the members. However, it was implied that this level of intimacy could be breaching some of the mothers' boundaries, as exemplified by a participant who left the group mid-session. The literature shows disclosures of traumatic experiences can occur in parent-infant groups often when participants are starting to trust the group and need to be handled sensitively by caring for the impact of the disclosure on all participants (Smith et al, 2010).

When interpreting this short example through the lens of the *motherhood constellation's supportive matrix theme*, both the support seeker who made the disclosure and the group member who stepped out, exemplify tensions between independence and reliance. Stern (1995) considers that for some women, keeping the support of the matrix might mean having to sacrifice independence or self-esteem to continue those relationships. In that sense, receiving support from the network can create a sense of psychological indebtedness for those who seek it (Kawachi and Berkman, 2001). In the short story described above, the group member conceded some independence in her decision to disclose the abuse during the group session, while the another group member established a boundary in her choice to leave the interaction.

In this first theme the experience of the parent's lack of trust was addressed through the development of co-operative power relationships, whether in the individual work setting or the group work setting. The approaches described focused on expanding the parent's support

matrix through a combination of the worker's persistence, the focus on the commonalities with the parent and empathizing with the parent's reasons for their lack of trust. In the final part of this theme, the social worker's role to create opportunities for social engagement among parents with similar difficulties was discussed. Social workers were deemed responsible for working both on their direct relationship with parents but also on the atmosphere and structure of the group to facilitate relationships. It was discussed that these relationships can bring positive effects and independence limiting effects for the members of the group.

6.2 The inner world of the parent and parenting behaviours

As it has been established above, the parents' feelings towards their situation had a connection to their level of trust and consequently to the way in which they formed relationships with the workers. In the following theme, we will explore first the descriptions of the parents' inner experiences including feelings and thoughts as described by the respondents and then the approaches used in infant services related to these issues.

6.2.1 The parents' feelings as described by the respondents

Respondents reported on that parents with mental distress seemed to have difficult feelings towards infant services, themselves and their baby. Respondents discussed a process of change in the routines, identity and relationships of these new parents. In that sense, these internal conflicts could be considered a normal part of the life crisis of becoming a parent, which represents a chance for parents to question their own identity and ways of being with others, and to create new ones if they wish to (Feldman, 1981; Stern, 1995; Stern and Bruschiweiler-Stern, 1998). These internal changes are referred to as the *identity reorganization theme* in the *motherhood constellation*, a change in role from career, partnership and daughter-mother orientation to the role of a mother (Stern, 1995). However, the parents described in the data seemed to be initiated into parenthood in environments that were unsupportive of this internal process and consequently the way in which they processed this reinvention of their identity was affected negatively.

She was so [...] filled from the delivery [experience], that it was a hinder. [...] It was in the way for her to see her daughter. [...] I was asking her if the daughter was hers, if she was a mum? And then she [would] burst into tears and she couldn't see if the baby was worth everything she was going through. [...] And it's...it was very painful for her to say it out [loud], because she couldn't say it even to her husband. [---] Not sadness...stone-faced. [---] So I could see [...] that she wasn't comfortable with being with her daughter. (R6, L3)

Respondents discussed the shame that parents felt for requiring parenting support, the invasive memories of negative experiences and mentally coping with the change of having a baby in the day to day routine. More to the point, respondents reported that parents did not believe they were managing to do what they *should* in their relationship to their infant or towards their partner. Parents were described as often believing that they *should* feel happy, emotionally connected to their child and able to care for the child at all times, a view that reflected some similarities with the images of the ideal parent-infant relationships discussed in theme 5.2. However, when these expectations did not meet the parents' real feelings, the contradiction created an internal conflict and seemed to be expressed in a sense of shame. Siegel and Hartzell (2004) relate shame to how a person's behaviour or that of others might reflect on that person's own self-assessment. The parents described in the data seemed to be

measuring themselves up to ideals that were difficult to achieve and that negated the social experiences they had been through.

Respondents also described the parents' responses to this experience of shame. According to Siegel and Hartzell (2004), different people often develop different coping strategies or *shame dynamics* to avoid or block this feeling when they experience it. Some of the avoidant shame dynamics were: refusing to talk about the issue with someone they otherwise had a close relationship with, focusing only on the behavioural dimension of a situation, or refusing to acknowledge the needs of a baby when the parent felt this reflected badly on their parenting capacity. In other words, a clear connection was made between the parent's internal conflict and their behaviours towards others. This was exemplified in the following quote:

She oscillated between seeing that the father to her child had big problems that harmed the child and not seeing it and it was even harder for her [...] to see... that she had something to do with this person who had subjected her to physical abuse, sexual abuse, psychological abuse. She found it hard to see [...] how this affected her child [...]. We formulated a hypothesis here in the house [...] that she was traumatised... [...] she displayed many symptoms of it. [---] For example, she forgot when she had given food, how much food, if she had bathed the baby or not, whether she had changed the nappy or not. [...] Very strong expression of emotions, she could go from being hysterical and breaking down over a silly thing maybe [...] to collecting herself very quickly, so very labile changes in her mood and emotional outbursts. [---] She could be very available for her baby, and talk with him, name nicely what he was doing, put in words his feelings, yeah... when she was herself a little bit more available. But later this could change very quickly. [---] When I think that he displayed he needed something that she could not manage to give, this could result in her saying 'so yeah, I can't hold him now, now you are not allowed to touch him, nobody is allowed to touch him'. (own translation, R8, L4)

The respondent discussed a mother who escaped an abusive relationship and due to that experience had difficulties focusing on the basic physical care of the baby and on emotionally engaging with him consistently. This could escalate to the point where the mother denied the baby's needs and prioritized her emotional needs of control by not allowing anyone to hold him if she was not able to do it herself. From an individualistic perspective, a parent's insensitive response to an infant's cues or prioritizing the parent's needs are behaviours related to the more primitive parts of the brain that run the 'fight or flight' responses (Siegel and Hartzell, 2004). These behaviours could be the mother's coping mechanisms to feeling threatened by the experience of shame.

On the other hand, this story can also be interpreted as an instance where the mother's *ghosts in the nursery*, or traumatic unresolved experiences, were triggered and got in the way of her ability to identify and respond to the cues of her infant (Fraiberg et al, 1975). When the ghosts in the nursery influence a parent's behaviour strongly, they can lead to repetitions of the same abusive behaviours that they were subjected to, leading to intergenerational patterns of disadvantage (ibid.). Attachment theory also supports the explanation of insensitive parental behaviours as a repetition of previous dynamics in the parent's relationship with their primary caregiver if parents don't acquire a new model of interactions through other relationships (Siegel and Hartzell, 2004; Newman, 2008). In that sense, *insecure attachment* styles foster an *internal working model* that makes the person predict that their emotional needs won't be met in the social world and the resulting defence mechanisms are escalating or minimizing the emotional volume of these needs, as well as a lack of internal connection with one's own physical and emotional needs (Siegel and Hartzell, 2004; Karlsson, 2012;).

The perspective of the *social approach to mental distress* can provide a different interpretation, where abuse in intimate relationships is considered a potential trigger to a mental distress crisis (Tew, 2005). Being subjected to these behaviours in an intimate relationship can affect the way in which a person relates to themselves and their environment by forcing them to become dependent on the abuser, forcing on them a skewed perception of themselves as unworthy of protection and unable to defend themselves (Plumb, 2005). These skewed perceptions can carry a sense of shame and conflicted feelings (ibid.). Due to the breaching of a person's boundaries, abuse in intimate relationships can cause a constant sense of anxiety, as the person feels unsafe without firm boundaries or power to negotiate these (ibid.). Furthermore, this experience can bring many overwhelming feelings with it, which might give the person a sense of feeling out of control, leading to an adaptation where the person needs to maintain a strict sense of control over their environment (ibid.).

Respondents in the data also focused on how parents described their infants as a sign of their representation of the relationship. They made note of mothers who they assessed as lacking *reflective functioning*, because these mothers interpreted their infants' actions from an adult and biased perspective, assuming the infant had the same complex intentionality as an adult. On the practical level of parenting, respondents discussed that sometimes this behaviour was also accompanied by discipline that did not consider the child's developmental stage and its effect on their behaviour. These comments and actions can be interpreted as *projections* as the mother imposes her own emotional conflict on the actions of the child without taking into account the child's developmental stage (Klein, 1975).

If the mothers' biased interpretations of their infants' behaviours are viewed through the lens of the *social approach to mental distress*, they could be interpreted as an adaptive response to the experience of shame. Another explanation for the experience of shame that these mothers might be facing could be caused by the contradictory expectations in social roles in society (Tew, 2005). In that sense, Williams (2005) writes that the dominant gender socialization oppresses women through messages of hostile and benevolent sexism. These types of sexism suppress women's freedom of action through the promotion of images of women as incompetent and having only a nurturing role in society, and the consequent comparatively lesser access to financial resources, status and choice of employment (ibid.). Therefore, when there is an incongruence between women's identity or actions and the normative societal expectations for women to internalize feelings, they can be more easily labelled as 'sick' (ibid.). These types of oppression could be closely related to the disenfranchised feelings described by the respondents, as these are the parents' reactions to attitudes about what they 'should' feel or how they 'should' behave according to the dominant group in society.

Having considered the experiences of shame and contradictory social expectations, as well as their effects on the parenting behaviours, now we turn to the second sub-theme that focuses on the approaches described to deal with these issues.

6.2.2 Approaches to work with the parent's inner experiences and behaviours

The approaches described by the participants were to provide emotional support, practical support and to practice mindfulness with the parents. Emotional support was provided through verbal and physical cues (holding) that let parents know that they were not alone facing the challenging situation. The support was focused on providing an emotional anchor for parents to engage in supported interactions with the infants. Or when parents seemed too overwhelmed, respondents also described providing direct care for infants with parents' consent, so that the parent could rest and return refreshed.

Touch was also used as a way to communicate emotional support and to provide a grounding sensation for the parent. When appropriate and respecting the service user's boundaries, touch has been highlighted in the literature as a powerful way to reinforce positive messages for service users (Wilson, 1982; Trotter, 2015). In relation to this, respondents discussed that they often had to assess during the first few weeks of meeting the parent, what type of intervention and to what degree touch might be welcome and appropriate for each parent. These ideas have been put forward by the literature as well (Kertay and Reviere, 1993).

The importance of creating emotional safety for the parent in their relationship to the worker was also highlighted:

So, my goal in the work with her was to make her feel as safe as possible in her relationship with me [...] to give her what she needs in order to... be as safe and available as possible in her relationship with her baby. (own translation, L4, R8)

The respondent spoke about a connection between the sense of security a parent might feel in a worker-parent relationship and that in their relationship with their baby. Taking into consideration the connection between insecure attachment, defensive mechanisms and insensitive parenting behaviours explored previously, this could be interpreted as an approach targeting the parent's *internal working model* to improve parenting behaviours. As it was discussed in the literature review, attachment can have an intergenerational dimension if parents base their parenting behaviours on an invalidating template of relationships. In that sense, Siegel and Hartzell (2004) have identified that individuals with insecure attachments can develop a different model of relating or an *earned secure attachment* through experiences of positive relationships later in life that support the development of coherency in one's personal history. Apropos this, respondents repeated throughout the interviews that they wanted to provide parents with an experience of being in a responsive and respectful working relationship with the professionals.

This approach of influencing the parent-infant relationship through positive interactions with the parent can also be framed in the context of *pro-social modelling*. The respondents identified and promoted self-regulatory behaviours as pro-social by modelling and reinforcing these during the interactions with the parent, an approach that parents in other studies on infant services have considered effective (Rosenström Domeij, 2010). Considering pro-social modelling from a different perspective, this approach can sometimes be considered manipulative or a superficial form of intervention as it focuses on here-and-now outward behaviours but does not address the underlying causes for these (Trotter, 2015). It is important to highlight that pro-social behaviour as described by the respondents was anchored on an explicit agreement between workers and families on the goals of the intervention and why specific behaviours were desirable in parenting. This approach can focus on the actions and behaviours displayed or the *explicit therapeutic plane* in the dyad, which in turn interacts with and could cause change in the representations of the relationship or *implicit therapeutic plane* (Brandt, 2014).

Respondents also discussed mindfulness in the individual and group work modalities, as another way to provide an internal anchor for parents to face emotionally challenging thoughts or feelings. In both modalities, mindfulness was practiced in the form of mental exercises to keep awareness of their own bodily reactions, their mental processes and states and how these influenced each other.

She gets [...] really agitated [...] by these [...] feelings and thoughts... like a fire. Because if she stays in her feelings, it doesn't grow like that. If she just feels, how is it

in her body right now? Not thinking ‘What will happen later? What will happen if I don’t go out now? What will happen if he doesn’t fall asleep? Maybe he’s ill’. I say: ‘Just stay in the present, feel how this feeling feels in your body. Where is it? Is it here’. [...] So then, it can help to be able to stay in the feeling and notice that it doesn’t go into catastrophe, because it’s just a feeling in your body. [...] And then step by step she has been able to... to not be so afraid of this feeling that comes. [...] And then there’s instead some sadness, maybe. [...] So then... then you can feel more feelings instead of avoiding some of them (R9, L1)

Mindfulness was presented as giving an opportunity for parents to expand the range of feelings they could feel, as they observed their own thoughts and reactions without judgement and gained a deeper understanding of how they were experiencing something. Moreover, the respondent also discussed the use of mindfulness to change long-established patterns of defensive mechanisms.

As described by respondents, mindfulness promotes the observation and acceptance of the present experience and the consideration of one’s thoughts and actions (Miller et al, 1995; Roemer et al, 2008). This is particularly important, if a person relies on an ‘automatic pilot’ when reacting to situations with a set coping mechanism, as it can often occur across different mental health problems (Siegel, 2007; Roemer et al, 2008). Considering this skill in relation to parenting, mindfulness can support better parental emotional regulation and the interruption of vicious cycles of negative interactions between parent and infant when they are dysregulated (Snyder, Shapiro and Treleaden, 2011). Mindfulness focuses on the *implicit therapeutic plane* of an interaction by influencing feelings, beliefs and representations that are counterproductive to sensitive parenting (Snyder, Shapiro and Treleaden, 2011; Brandt, 2014).

Considering the previously explored link between the parent’s *internal working model* and their parenting behaviours, mindfulness can be considered an approach promoting *earned secure attachment* through fostering self-knowledge (Siegel and Hartzell, 2004; Snyder et al, 2011). Mindfulness also promotes *bilateral integration* by exercising the ability to think about how we feel and feel about how we think, which is evident in the compassionate self-awareness and self-talk exercises (Siegel and Hartzell, 2004). Respondents reported that it can also provide a new way of relating or feeling about previous traumatic experiences. This is especially important in the case of parents with *disorganized attachment* experiences, as it can foster a more coherent narrative (ibid.).

In summary, in this theme the respondents described parents who experienced shame, contradictions in social expectations and a breach of personal boundaries and control over their emotions in relationships. These experiences of powerlessness continued to resonate emotionally in their relationship with their infants, affecting their ability to acknowledge and respond to their infant’s needs and creating vicious cycles of negative interactions. Workers provided different techniques for grounding the parent including practical help, emotional support and mindfulness. These approaches worked on the implicit and explicit therapeutic planes of the interaction by modelling, providing the parent with opportunities to challenge unhelpful internal working models and supporting them to find calmer ways to relate, ways that could put forward the authenticity of the relationship in that specific parent-infant dyad.

Having considered some of the internal factors that affect the behaviours of parents, now we turn to the descriptions of interactions between parents and infants.

6.3 Difficult parent-infant communication patterns

As described previously, good communication patterns between parents and infants was one of the goals for the intervention in infant services. This is closely related to the theme of *primary relatedness* in Stern's (1995) *motherhood constellation*, which focuses on how the parent develops the infant's interpersonal skills through the parent-infant relationship. This theme will portray descriptions of difficult communication patterns between parents with mental distress experiences and their infants, and the approaches described by the respondents to promote good communication patterns.

6.3.1 Difficult communication patterns:

Respondents identified difficult communication patterns between parents with mental distress and their infants through the child's cues. As in their descriptions of ideal parent-infant relationships, they interpreted the parent's behaviours and the child's sleeping and eating routine as part of a mutual communication system.

When somebody has some difficulty to interact [with the baby], one often sees that... the child is dysregulated and that they don't get into a rhythm, that they confuse day and night, or that [the parent] can't tell how much the child sleeps or eats, that it is chaos. (own translation, R2, L1)

Respondents paid attention to the child's cues as signs of whether the child's needs were being met, signs of the quality of the interactions. The parents seemed to portray signs of mental distress to the point that this compromised their acknowledgement of the child's cues and of their needs, as evidenced by their difficulties tracking how the child's most basic needs were being met. Throughout the interviews, the respondents also discussed significant delays in physical development and infants turning away from the parent constantly as signs of negative communication patterns. Other behavioural negative signs in infants included irritability expressed through inconsolable crying and a lack of interest in natural urges like exploring the environment or eating, a view aligned with previous literature on infant services work (Skagerberg, 2010; Malmquist Saracino, 2011).

Furthermore, it was also highlighted that the actions of both infant and parent had repercussions in the behaviours of the other person.

An unhappy child or a demanding child. She would not be able to manage that. [---] So [the baby] has been maybe very kind or... very easy and now that he is a bit older and has displayed his cues, she can see him better. (own translation, R6, L3)

[The baby] started to sleep more and more, [...] and it is a way for the child to turn off or to disappear from a situation that is too tough. Yes, so according to the child's development, he should be awake for longer, but instead he started to sleep more. Yes, very often in situations [...] when the mother wanted to talk more and be with him. [--] I think that this presumably made it even harder for her to work at being more available and safe and that instead it caused her to... want to be with him even more and to wake him up, which of course made it even worse. It became a vicious cycle. (own translation, R8, L4)

Respondents highlighted the behaviours of infants as either influencing or being influenced by the behaviours of the parent, as evidenced by the characterization of "a demanding child" vs "a very kind child" and the change in sleeping patterns in the last quote. In relation to these characterizations, the literature has identified that infants can have different inputs into the

style of interactions with the parent by displaying cues that are easier or more difficult to understand (Lindberg, 2000; Hall, 2004). In that sense, *easy babies* refers to infants that comply with a regular eating and sleeping routine, and can accommodate to new situations without major complications (Lindberg, 2000). In opposition to this, the respondent mentions “demanding children” or *difficult babies*, who can struggle to establish these routines, can react negatively to new situations often and have difficulties adapting to change (Lindberg, 2000). These variations in presentation are identified as the baby’s temperament, which interacts with the parent’s capacity to respond to that specific temperament facilitating or hindering the child’s development (Hall, 2004). Despite these different presentations and possible configurations of interaction styles, infants still require predictable care that is responsive to their cues so that they can develop their potential (Winnicott, 1988).

The agency of infants in response to certain parenting styles has also been documented in attachment literature. Infants are able to register patterns in how their attempts at engagement are responded to by their primary caregiver (Winnicott, 1971), and to adjust these to maximize their chance of getting their physical and emotional needs met (Karlsson, 2012). The subtlety of these interactions was depicted by Winnicott (1971) in the following quote:

The baby quickly learns to make a forecast: ‘Just now it is safe to forget the mother’s mood and be spontaneous, but any minute the mother’s face will become fixed or her mood will dominate, and my own personal needs must then be withdrawn otherwise my central self may suffer insult’ (p. 113).

The descriptions of difficult interactions in the data were aligned with descriptions of personal accounts of parental mental health problems, when parents seemed to intermittently bypass the infant’s cues and where the parent’s emotional needs were prioritized in the interactions (Williams and Cowling, 2008). These types of out of step interactions where somebody’s expressed need goes unanswered are identified as ruptures (Siegel and Hartzell, 2004). Ruptures can occur in any relationship through limit-setting, however very emotionally upsetting ruptures that occur continuously and are not resolved (*toxic ruptures*) can give the child a great sense of disconnection from the mind of the parent (ibid.). According to neurobiological research, toxic ruptures occur due to parenting behaviours that are run by the more primitive parts of the brain focusing on ‘fight or flight’ responses (ibid.). When the parent’s more primitive parts of the brain are fully engaged in reacting to behaviours due to feeling threatened, it is difficult for them to engage in reconsidering their behaviour or the mental state of others, as this involves more newly developed sections of the brain (Siegel, 2007). In other words, these out of step interactions are closely related to the brain focusing on reacting to the perceived threat, which hinders the meta-cognitive ability of *mentalization* (Seligman, 2014).

This lack of *mentalization* can affect the parent in other dimensions of their life too. Seligman (2014) established a link between lack of mentalization ability and low affect, difficulties in relating to others, unbalanced self-esteem and self-concept, and pathological idealizations. This implies that the toxic ruptures described by participants can be a sign of a lack of mentalization affecting how the parent may view themselves and compromising their ability to relate positively to others. Furthermore, an infant’s development of their potential to mentalize can be compromised if the caregiver is unable to mentalize and to support the infant’s emotional regulation by reflecting back and naming the feelings and needs expressed by the infant (ibid.). Considering this in relation to the descriptions provided by respondents, the potential for an intergenerational cycle of lack of mentalization, poor emotional regulation and limited ability to relate to others positively is highlighted.

Having considered the possible processes behind the difficult parent-infant communication patterns described by respondents and the risk they pose to the infant's development, now continue discussing the approaches described when working with these situations.

6.3.2 Individual work modality approaches to promote good communication patterns

Respondents talked about the importance of promoting the parent's own internal motivation to get to know their child and to become more experienced at reading the child's cues in everyday routine situations.

We try [to] make the mother [...] attentive towards the child and curious about the child, [---] we maybe refer to the child and 'look at you doing this or that', [...] we try to bring the mother to the interaction in different ways. [...] And the power lies with the child's cues and [...] they can be of help. And the mother just becomes more sensitive towards them. A main model or method to make sense of these cues, sometimes we can work with *Marte Meo*, it works quite well with pictures. It can be easier to see a picture than to speak to the child in the room, it can also incite curiosity. (own translation R1 and R2, L1)

According to respondents, the 'dialogue' between parent and infant developed during these experiences would in turn contribute to the parent engaging more in interactions with the infant. This excerpt is aligned to the characterizations of ideal parent-infant relationships in theme 5.2, highlighting the importance of increasing *maternal sensitivity*.

Respondents discussed different approaches to highlight the child's cues including the use of words, pictures and modelling behaviours, which worked on the *explicit therapeutic plane* of the interactions. Respondents implied that consistent changes in the parent's behaviours or *maternal sensitivity* could influence the style of the interactions in the future. The importance of these approaches relied on the assumption that these interactions are the vehicle through which infants experience the mother's inner representations of their relationship in the *implicit therapeutic plane* (Stern, 1995; Kristiansen, 1998). Moreover, as previously discussed, interventions in the explicit therapeutic plane can have effect on the implicit therapeutic plane.

While using these approaches, respondents discussed the need to constantly assess the interactions between parents and infants. The observations focused on how parents and infants responded to each other in everyday situations and on the identification of patterns in their non-verbal and verbal dialogue. These observations are consistent with the approach of *interaction assessment*, where the worker can observe everyday repetitive parent-infant interactions through the lens of their own experience, following a specific model or knowledge from the literature (Stern, 1995; Lindberg, 2000). Throughout the interviews, the respondents reported using their own professional experience, knowledge of attachment theory and specific models like *Marte Meo* to consider the cadence, nearness, warmth and leading patterns in the interactions. The focus on attachment theory has been used in similar infant services to identify signs of the infant's level of security in the relationship and how the parent balances leading the interaction versus allowing the infant to explore the environment (Kristiansen, 1998; Williams et al, 2008). On the other hand, the focus on observing only the physical interactions without extrapolating psychological interpretations based on the past history of the parent is consistent with an *ethological reading of microevents* (Stern, 1995). The importance of *microevents* is highlighted in the context of difficult parent-infant

communication patterns caused by mental distress experiences, as these are the vehicle for the infant to experience the mother's representations from the implicit plane of interaction and they create predictable patterns of communication for both parties (ibid.).

Another approach to promote good communication patterns as described by the respondents was calling attention to the child's cues verbally, as exemplified in the following quote:

I could then see for example that the baby is now... needs peace and quiet. I can go and see it and say to the mother that 'calm, calm, just hold the baby so that he feels it, so no sudden movements', I can say. Maybe the mother tries to rock the baby strongly... very strongly and I beg her 'calm'. (own translation, R7, L4)

Respondents drew attention to the infant's unanswered cues verbally during parent-infant interactions either by using the perspective of observants or by pretending to be the 'voice' of the baby. The later approach has also been put forward in other infant services as a way of promoting *mentalization*, *maternal sensitivity* and desirable parenting behaviours (Carter et al, 1991). Calling attention to the infant's cues could have positive effects in the implicit therapeutic plane by fostering a secure internal working model for the infant by increasing the frequency of instances where the infant's cues are validated.

Respondents also recounted modelling the desired parenting behaviour in the individual and group work modalities to promote changes in the interactions. In the individual work modality, showing parents how to respond to the infant's cues or giving verbal instructions when needed were discussed. In the group work modality, observing the development of an older child in the infant group was described as an opportunity for parents to understand the future of their own child's development and their future needs. This approach can be framed as *pro-social modelling*, where the worker demonstrates and reinforces the repetition of desired behaviours, while challenging the undesirable ones (Trotter, 2015).

Marte Meo was mentioned by the respondents as another approach to steer the parent's attention towards the child's cues. This approach provides the opportunity to work at the caregiver's pace focusing on short scenes of video-recorded routine activities between parent and infant, towards unbiased observational skills in interactions (Downing et al, 2014; Høivik et al, 2015). By highlighting the moments where parents meet their infants' needs, the practitioner fosters further motivation to repeat these positive patterns, focusing on the explicit therapeutic plane of the interactions (Downing et al, 2014). Throughout the interviews, the majority of respondents described *Marte Meo* as an approach that was well-received by parents due to its focus on highlighting the positives and making the parent their own role-model. However, some respondents considered that for parents who were already acutely aware of their difficulties in interacting with their infants and felt insecure in the relationship with the worker, having videos of these interactions could be perceived as threatening. These reflections seemed to take into consideration the difficult context of power imbalances in the worker-parent relationships described in themes 5.1 and 6.1.

6.3.3 Group work modality approaches to promote good communication patterns

Following the logic of *Marte Meo*, respondents also described highlighting the positive interactions between parents and infants in the infant group setting as another relevant approach.

You have to stay aware and attentive and wait for the moment when something glorious happens and you can say ‘see, look what happened!’, [because] it’s then you can strengthen that spark...and sometimes it’s very small movements and you have to be able to watch out for them for a long time. So, it’s something that has to do with your ability to be relaxed and attentive for a long time in a very...everyday environment. (R4, L2)

Respondents reported needing to contribute to the welcoming atmosphere in the group by presenting as calm and relaxed, but being constantly aware of the interactions in the group to reinforce the positive behavioural patterns. The idea of workers being able to reinforce desirable behaviour through praise is linked to promoting the parent’s internal motivation and *self-efficacy*. Self-efficacy implies that parents with a firm belief in their capacity to parent their infant appropriately are more likely to persist in attempting to support the child despite difficulties (Newman, 2008).

Considering Tew’s *four modes of power*, social relations can enable empowering or oppressive identities and social behaviours through the use of *co-operative* or *collusive* power, affecting self-efficacy in the production of these identities (Tew, 2011). This process can occur through two strategies to establish social relations: bridging and bonding (*ibid.*). Bonding is based on a sense of common identity with others and can allow access to mutual support, but this identity can also exclude others who are considered different (*ibid.*). On the other hand, bridging refers to the alliances built between people in a disadvantaged position and those in power to achieve some common aim (*ibid.*).

The respondent’s role in organising and leading the infant group sessions can also promote bonding and bridging for parents with mental distress experiences. The group session can serve the goal of promoting co-operative bonding relationships in the group between peers and bridging alliances between workers and parents to support the child’s development. By highlighting positive interactions between parents and infants, the workers contributed to the parent’s sense of self-efficacy and celebrated their achievement in a nurturing environment where their peers could recognize it too. Respondents also emphasized that the group sessions provided opportunities for parents and infants to have a good time together, contributing to the participants’ own sense of being able to provide something good for their baby. Similar views on the role of infant groups have been noted in other Swedish infant services (Kristiansen, 1998). Organising infant groups then seem to serve the triple role of promoting self-efficacy, a common identity with other parents and a closer bonding relationship between parent and infant, processes that could in turn increase the parents’ feelings of parental identity and their access to social support. Studies have put forward social support and maternal identity as predictors of *maternal sensitivity* (Shin et al, 2006), which seemed to be the target of these approaches.

In summary, this theme focused on the struggle of parents to fulfil the task of *primary-relatedness* from the *motherhood constellation* (Stern, 1995). Respondents in the data described toxic ruptures where the child’s cues were not responded to appropriately, creating a sense of disconnection and lack of validation. Through the perspective of attachment theory, both parent and infant can contribute to the reinforcement of these patterns by continuing to display defensive behaviours in response to feeling emotionally threatened. Mediating factors like *mentalization* and *maternal sensitivity* are therefore very important. The respondents in the data discussed multiple approaches to promoting good communication patterns in the parent-infant dyad including assessing interactions, speaking for the baby, pro-social modelling, Marte Meo and group infant sessions. These approaches seemed to work on both the implicit and the explicit therapeutic planes of the interactions towards clearer

communication patterns. The approaches proposed by the respondents went beyond 'prescribing' how behaviours needed to change and focused on organically promoting the parent's internal motivation for change through self-efficacy, co-operative bonding and bridging, and providing opportunities for natural mutual enjoyment to emerge. Research on interventions for post-natal depression also supports the efficacy of this type of multiple method approach (Clark et al, 2008).

Having discussed the complexity of the difficulties in establishing worker-parent relationships, the connection between the parent's inner experiences of distress and their behaviours towards others and the processes behind the difficult interactions in the parent-infant dyad, it is evident that both parents and infants come to infant services with complex needs. The next chapter will continue presenting the results and discussion in relation to how the practice context affects the professionals.

7. Results and discussion – the effect of the practice context

This chapter will put forward descriptions of how the parents and infants' needs and legal rights affect infant services work. The chapter includes two themes: conflicting responsibilities for infant services workers and the emotional demands of the work. The themes will be presented using a mixture of quotes and comments summarizing the data, which will be analysed using mainly theories from the theoretical framework focusing on the influences of the social world and power relations.

7.1 Conflicting responsibilities for infant services workers

In relation to the target population they work with, infant services workers have a responsibility to adhere to the Social Service Act, but their work is also affected by the parent's legal rights to family and privacy (Weir, 2004). As mentioned in the analysis of theme 6.1, the potential for social service intervention on these families fosters a lack of trust from the parents and fear that can exacerbate experiences of mental distress. The needs of parents and infants create a number of demands on infant services workers, these needs together with infant services' legal obligations lead to a complex context to work in. This theme will present and analyse the descriptions of this context first and then the approaches that the workers use to manage it.

7.1.1 The infant's needs and the parent's needs in infant services

Respondents described a tension between their perception of the parent's voluntary engagement with infant services and the mistrust expressed by parents. However, as previously discussed in theme 5.1, referrals occurred under a number of circumstances, which could have also affected the parent's decision on whether to engage with infant services.

When somebody ends up here [closed ward institution] it is like saying to a parent that you can't manage... you are not trusted. [...] There are so many concerns in relation to you that you must be here [whereas] in a more open ward service there is nobody who decides [on behalf of the parent] in the same way, so people are not questioned in the same way at all. (own translation, R8, L4)

It's especially [difficult] if they feel a threat that otherwise they take away the children. It's quite difficult motivation, so there is no way in [to the relationship] with the family, they come, they just make somebody else pacify the social service. And they don't dare either [...] maybe talk about their own concerns. They believe that it will be used in the meeting and 'you [will] take away my children'. (own translation, R1, L1)

Respondents differentiated between closed ward institutions and open ward services as exemplified in the quotes. They perceived that in the former, adversarial relationships between parents and workers were more likely to develop due to the circumstances around the work as in the first quote. However, parents could also take an adversarial stance if they felt unsafe in their relationship to an open ward service while undergoing a social service investigation as was the case in the second quote.

The exercise of ethical and legal responsibilities to ensure the basic safety of the child like making a risk assessment and passing on information onto the social service authorities can be

perceived by parents as a threat and a disruption (Fraiberg et al, 1975; Clodman, 2004). However, it can also be used as a reinforcement to ensure the parent's compliance and engagement with a service (Fraiberg et al, 1975). In this context, instead of demonstrating more internal motivation, some parents seemed to engage with infant services in a superficial manner only to avoid the negative reinforcement of a more intrusive intervention from the social service. According to respondents, these dynamics made it difficult for parents to engage in a deeper relationship with the workers and to get the support they needed to improve their relationship with their child. In relation to this, Clodman (2004) noted that due to perceiving the social service interventions as stigmatizing and as an affront to their sense of self-efficacy, parents are likely to deny any possible difficulties or engage in desperate attempts to demonstrate their parenting capacity.

Respondents described the needs of parents when they felt threatened by the context of the interventions. In that sense, respondents conveyed that a poignant conflict could occur between the parent's needs and the infant's needs:

She... wanted to have him more like a... to hold him close to her all the time even when he showed that he needed something else, or even when she also got scared many times. [...] So he was delayed in his gross motor and fine motor development due to the fact that he didn't get to touch things with his hands or move about or lie on his tummy. Consequently, this led to him being [...] unable to do the things that he would be expected to be able to do as a baby of a certain age. (own translation, L4, R8)

In this description, a parent's need for emotional security and to have her baby close to her could jeopardize the child's developmental needs. Considering the context of the referrals to infant services, it could be argued that with time, some of the approaches from theme 6.1 could be used to build trust with this parent. Nonetheless, this conflict does not just refer to negotiating the shape of the intervention, but also its target and duration. In relation to this, Fraiberg et al (1975) identified that the urgency for the infant's emotional needs to be met and for development to be supported push the intervention to be effective in a very short timeframe, while the development of trust with the parent and addressing the parent's negative patterns adjusted to historical disadvantage requires a long time. Respondents reported that at times the cues showed by infants were already so alarming that workers had to convey to the social service that the child could not wait for the parent to change their behaviours, which could potentially lead to a child protection removal.

The challenges of working within legal frameworks that enforce social control like for example the Social Service Act, while having a mandate to support the rights of service users have been documented in the literature (Fraiberg et al, 1975; Clodman, 2004; Hardy, 2015; Trotter, 2015). These challenges are related to how the care and social control tendencies in social work are managed. When using social control practices, social workers search for and discourage undesirable behaviours by society's expectations, favouring an individual responsibility rationale for social problems (Margolin, 1997; Hardy, 2015). In the case of the respondents, this would constitute discouraging child abuse or exposure to harm, by seeking individualistic explanations for the patterns of abuse. On the other hand, the care component of social work tradition prioritizes the person's self-determination and relies on structural explanations to understand social issues (Hardy, 2015). For the respondents, this could be prioritizing the family's right to self-determination and supporting them to address structural disadvantage. Both dimensions of social work, care and social control, have been historically dichotomized, however both continue to be complementary parts of social work (Hardy, 2015; Okitikpi, 2011; Trotter, 2015).

On the other hand, respondents also noted the inherent tensions between protecting the child's rights to safety and protecting the rights of the family to self-determination and to remaining together.

It's a difficult balance, it shouldn't be easy to, to take a child or to force a family to get help either, but I think that we have seen too many families where it takes too long time before they get help. (R5, L3)

Respondents disclosed that in some cases their opinion for the need of statutory intervention did not match the assessment of the social service, resulting in the social service not intervening in the referred family and respondents managing the risk of harm to the child on their own using non-statutory approaches. This made the intersection between the care and control dimensions of social work even more poignant. In that sense, Smith identified that workers can simultaneously feel powerless in the face of organisational processes they can't control and unsure as to how to control the power they have over service users (Okitikpi, 2011)

Having discussed the ways in which the needs of parents and infants and care and social control intersect in infant services work, now we turn to the strategies that the workers used to manage this situation.

7.1.2 Approaches to manage conflicting responsibilities

Respondents acknowledged the competing demands of the parents' and the infants' needs, as well as the tensions between care and social control in their roles.

You need to balance that, 'my need to talk about myself' and 'my need to have a relaxed atmosphere', where it focuses on the child, where we don't feel that it has to be so heavy. (R4, L2)

We leave our impressions and we leave our assessment, our proposal to the social service, but it is the social service who decides. (own translation, R7, L4)

Respondents managed these competing demands by constantly attempting to balance their time and attention between the needs of one group and another in alignment with results from previous studies on infant service workers' perceptions (Norling Bergdahl, 2007). However, in this study respondents also actively described the boundaries to their responsibility, limiting their role to gathering information about the families and the construction of an assessment of the consequent risk of harm to the child. They highlighted that they were not responsible for weighing this assessment or considering the consequent course of action. Throughout the interviews, respondents also identified that sharing information with other professionals working with the same family was part of their responsibility to maximize the benefits to the family and minimize risk of harm to the child. Results from previous studies on child protection workers and on probation officers showed that they also favoured *role restriction* as an approach to managing care and social control tensions (Day, 1981; Trotter, 2014).

The workers' establishment of these boundaries to the role could be interpreted as a form of *self-mystification*, where workers obscure the social control elements of the work under the images of genuineness and positive results in social work interventions (Margolin, 1997). This does not presume a purposeful deception, but is part of a tradition of narratives that have allowed social workers to find internal psychological coherency, psychological distance from

service users and effectiveness in their roles as social regulators throughout history (Day, 1981; Margolin, 1997). Nevertheless, from the perspective of service users, *self-mystification* might not be desirable, given clear communication on how workers could use power and role clarification have been linked to more outcome satisfaction for service users (Trotter, 2014).

Throughout the interviews, respondents also established boundaries for the target population for infant services. Open ward services were presented as voluntary services specialized in families where there was risk to the parent-infant relationship, but not such high risk that constant supervision was required. They identified that families with high risk of a child protection removal needed to attend closed ward services, as the needs of all parents could not be met using the same approaches and service provision style. Some high-risk factors identified by respondents were active drug use, unmanaged psychotic episodes and social problems that affected parenting to the point that basic care of the child was compromised. Finally, unwillingness to engage with parenting support services could also increase risk if other factors were present.

It was put forward that families with more complex needs that required more intensive supervision were the responsibility of the social service. This transfer of responsibility was done through the social service notifications or through proposals for families to self-refer to the social service. The shift in responsibility for the social service to intervene in high risk situations can be related to the rise of the *risk discourse* in society. In this discourse, service users are considered to be *at risk* of harming themselves or *a risk* to others due to not taking up the individual responsibility to function pro-socially or having a ‘flawed identity’ that hinders them from acting morally (Hardy, 2015).

Under this discourse, the role of the social worker is to differentiate through risk assessment between those who can self-manage risk related behaviours and those who can’t, and require interventions that are more control based (Rose, 1996a). This changes the role of the social worker to somebody that needs to be proficient in gathering the necessary information and calibrating it to predict the behaviour of service users (ibid.). The purpose behind these approaches is of course to ensure that everyone has access to freedom without causing harm to themselves or to others (Tew, 2006). As infants are dependent on others to have their needs met and have limited capacity for protective behaviours (Bowlby, 1965), this is especially relevant in the case of families facing parental mental health problems.

Nonetheless, the complex intersection between the *care* and *social control* dimensions of social work is undeniably present in infant services work. Moreover, the *risk discourse* has also become relevant in this arena and the consequent reliance on some control approaches amongst care focused approaches is evident. The danger in this situation is that workers can find it more difficult to maintain the focus of the work on the parent’s needs (Hardy, 2015). Parents in turn can perceive this process as a use of *oppressive power* towards them, as they might realize the ‘othering’ or stigmatizing potential in these practices (Tew, 2006). Nevertheless, the use of power can be a double-edged knife depending on the perspective and the consequences for each person, the same mobilization of power can be perceived as *oppressive* by parents but as *protective* by infants (ibid.).

As described above, in some situations respondents distanced themselves from the more obvious social control approaches and presented it primarily as the responsibility of the social service. However, in other situations respondents shifted back and forth between discussing care and social control elements:

There are of course parents [...] who try to make a joke out of everything and there one must bring them back and say there is of course a reason why you are here. There

is of course a concern around why you are here, how it will go. So in relation to you having a baby and so on. [...] So I often use the baby then. And so one looks at the baby 'oh no, but now I think that Kalle wants to have his mum's attention'. So that in this way, one brings [the parent] back in a [...] we call it a harmless manner. (own translation, R7, L4)

Respondents described the mixed use of the care and social control elements by providing both support but also bringing the risk to the child into the narrative by highlighting the child's cues, changing the topic of conversation or making referrals to the social service. As another example, another respondent reported working closely with a mother living with an abusive partner, providing her with intense emotional and practical support but also preparing a child protection notification due to the risk of emotional abuse to the children. This perception of the role of the worker as flexible evidenced in these examples, was also highlighted as a strategy by workers in probationary services in the context of care and social control tensions (Day, 1981). Considering this approach from the perspective of Tew's (2006) *four modes of power*, respondents discussed the use of *co-operative power* and *protective power* towards parents by creating bonds with them through 'reciprocity and mutuality' and organizing resistance against oppressive others. Nonetheless, they also mobilized *oppressive power* when they used social control approaches to bring the social service services into the narrative.

In relation to this, Trotter (2014; 2015) and Day (1981) advice that both care and control dimensions in social work need to be openly acknowledged in the relationship with the service user, rather than being dichotomized. Even if one dimension becomes more dominant in any given situation (e.g. a parenting assessment during an investigation), the other dimension is always present as the same relationship between worker and family is used later to provide help or challenge anti-social behaviours (Trotter, 2015). Discussing the implications of these two dimensions to the relationship with the parent is an important part of role clarification (Trotter, 2014 and 2015). Studies have linked better results for service users with practices where non-negotiable behaviours are discussed, as well as their potential consequences (Trotter, 2015).

In summary, this theme presented the complex intersection between the parent's needs and the infant's needs in the context interventions that encompassed both care and social control. The contradiction between different interests and the predominance of the risk discourse in society have supported the use of role clarification as a method to establishing boundaries between workers' care and social control responsibilities. Alternatively, workers adeptly mobilized a mixture of co-operative, protective and oppressive power within the same relationships to manage their alliance to multiple interests. These descriptions depicted the character of power as constantly changing, produced in relationships and dependent on time and circumstances. These descriptions reveal the multi-layered complexity of the power relations context of infant services work, in which contradictory tensions can affect the relationships with parents, the focus and duration of the work and the approaches chosen.

7.2 The emotional demands of the work

It has been recognized in the literature how working with people who have suffered traumatic experiences can engage the professional at an emotional level, as the bulk of the work relies on interpersonal relationships (Harrison and Westwood, 2009). This last theme in the results

and discussion section focuses on the respondents' descriptions of how infant services work affected them emotionally and the strategies that they used to manage this issue.

Respondents disclosed that the working relationships they formed with parents could be emotionally taxing due to the constant negative experiences they were exposed to by the families they worked with:

You must try to form an attachment with the parent and that is quite demanding on you as a professional, you have to have the energy for it. [...] You get so many...interactions all the time. [...] Most parents question me in circles, their feelings go in circles: 'I can't actually do this', 'I am worthless', 'I am bad'. And they lay all of that on us. (own translation, R8, L4)

Some families require different things from us and [...] you may need to go to the staff room and just have a lie-down in order to be able to go back to the family and be professional and helpful. (own translation, R7, L4)

Respondents reported needing high emotional energy to be effective in the work, because of the need to demonstrate unconditional understanding and positive energy to service users, even when these responded in a negative manner. To do this, respondents had to be aware of the service user's emotional needs at the individual and group level in the group work modality throughout an extended period of time. Being physically and emotionally close to others can be energy consuming if there are inherent contradictions in the relationship. Considering the tensions between the *care* and *social control* elements in infant services that cause strong emotional and behavioural reactions on the parents, and *role restriction* and *self-mystification* in the workers, it would be natural for parents and workers to have differing views of the role of the infant services worker. The former might consider the social control elements as predominant in their direct experience, while the latter might focus their perception more on the care elements based on the role expectations inherent in professional education and the organisational context (Okitikpi, 2011). This lack of consensus on role negotiation can cause *role ambiguity* or "uncertainty about what constitutes acceptable practice" for the respondents (Day, 1981, p. 22). According to *cognitive dissonance theory*, a natural tendency of the human brain is to strive for coherence between different pieces of knowledge such as attributes of something, attitudes towards it and rationales for behaviours (ibid.). Information that threatens this coherency is naturally taxing for the brain (ibid.). This is exemplified in the link between role ambiguity and work dissatisfaction in other contexts where social workers also met care and control tensions (ibid.).

Some respondents discussed that the intersection of their and the service user's characteristics could make the work more emotionally demanding:

And it was tough for me, cuz' she was my age. Most of our mum[s are] younger and I... I don't identify myself with them [...] but she was a lot like me, so [...] it was a challenge. But we ha[d] a very good supervisor at that time, so I took a lot of it [to them]. (R5, L3)

The respondent described marked similarities with this mother that were unusual and made the work more difficult for her to the point that she required support. Historically, social workers have rationalized the social control elements of the work with a narrative of moral distance from the service users as a group and causing good change in others (Day, 1981; Margolin, 1997). Consequently, if this is one of the discourses underpinning the coherency of the intervention, it might be threatened by similarities that deny the historical rhetoric of

service users being in a separate group that is disadvantaged by class and the choices they have made.

As identified by one of the respondents, there is also risk of psychological strain on the practitioner in the exposure to the parents' and the infants' traumatic experiences and their aftermath.

If children are mistreated and [...] we are with them and see parents who are not able to give children what they need, [...] we as staff must be open to talk about these difficult matters and feel safe with each other. (R2, L1)

The respondent discussed situations when infant services workers work with parents while suspecting that the risk to the child is increasing, which links to the dilemma of how the parents' and infants' needs affect the duration of the intervention, as discussed in theme 7.1. There is a risk of psychological harm for practitioners, as the frameworks they use to understand the world, themselves and others can be changed negatively for the long term (McCann and Pearlman, 1990). This process is called *vicarious traumatization* and can affect the worker's basic underlying assumptions such as inferences about safety, one's power of influence in the world, views about human nature and even the own *internal working model* in relation to attachment experiences (ibid.). Vicarious traumatization can affect everyone differently depending on which frameworks are prioritized for them, but overall it can be a socially isolating experience, as these changes in frames of reference might not be shared by others (ibid.).

The strategies discussed by respondents to manage these emotional demands were related to setting boundaries between their work and their personal life, and reaching out to others for support. Respondents recognized the value of their colleagues' emotional support in supervision and during day to day interactions to maintain their emotional energy high. They highlighted the importance of well-established trusting relationships in the workplace so they could feel comfortable showing vulnerability in their professional role. Respondents disclosed that short 'debriefing' conversations with colleagues before leaving work were often helpful to change their frame of mind to the private sphere. Studies on how professionals manage *vicarious traumatization* in similar practice settings have also highlighted the importance of peer and supervision relationships where their experience can be validated, where they can share strategies to keep healthy and support each other in identifying when the work is affecting them too much (McCann and Pearlman, 1990; Williams et al, 2008; Harrison and Westwood, 2009).

Maintaining firm boundaries between work and personal life was also identified as very important. This could take the form of physical boundaries or psychological boundaries between the service users and the workers. In that sense, practitioners' interpersonal boundaries need to allow them to be empathic to service users, but to also maintain their personal integrity and their ability to view the same experience from different perspectives to be useful to the service user (Harrison and Westwood, 2009). For example, a respondent also discussed the importance of creating hypotheses about the reasons for service users' behaviours as a way of distancing herself emotionally from threatening or negative behaviours displayed by service users. This approach is conducive to understanding the own limitations of influence as a worker and having realistic expectations of one's role and of other people's behaviours (Harrison and Westwood, 2009).

This last theme in the results and discussion section has put forward the respondents' descriptions of the emotional demands they experience in infant services work. Respondents felt that they needed high emotional energy to practice in this area, not just because of the

amount of time and how close they were with service users, but also due to role ambiguity issues and the risk of vicarious traumatization. Workers relied on putting psychological and physical distance between themselves and the emotionally taxing parts of the work; and on the social support of others to combat the isolation, sense of helplessness and frustration that they could encounter in their work.

This chapter has brought up the relevance of the care and social control tensions, the contesting needs of infants and parents; and the interaction of secondary trauma exposure and the workers' own internal experiences in understanding the complexity behind infant services work. At the same time, it has also portrayed sophisticated approaches to thinking and doing that workers use to manage this complexity.

8. Conclusions

This thesis focused on the descriptions of approaches used by infant services workers in supporting good parent-infant relationships between parents experiencing mental distress and their infants, on the challenges they encountered, and the power relations implications in this work. Going back to the original research questions, a summary of how the results have answered each question will be presented. Then we will turn to discussing the study's implications for practice. Finally, a reflection on the limitations of the thesis and recommendations for future research will be presented.

8.1 Summary

8.1.1 What processes do professionals believe cause attendance to infant services?

The workers understood that parents could decide to come to infant services of their own volition or be influenced by the power vested in the recommendations of other services. In most cases, they identified experiences of mental distress in the parents rooted in their socially invalidating experiences, consisting of a multitude of social problems. This intersection caused further disadvantage by depriving parents of some sources of power like social support from others, self-efficacy, the ability to manage interpersonal boundaries successfully and insight into vicious cycles in behaviour. Respondents made a link between the parent's perceived diminished power and the risk that multiple disadvantage could undermine the parent's ability to meet the child's emotional and physical needs at a sufficient level to support the infant's development.

8.1.2 How do professionals characterize ideal parent-infant relationships?

Professionals demonstrated a view of ideal parent-infant relationships consistent with Stern's (1995) motherhood constellation. Professionals focused on reflective functioning and maternal sensitivity as evidenced through mutual enjoyment of interactions between parent and infant, reciprocal verbal and non-verbal communication and predictable sleeping and eating routines. These views are consistent with attachment theory, developmental psychology and neurobiological research. Respondents acknowledged that the ability to parent at this level was a skill acquired through time and practice for many parents, which mirrored the intensification of the emotional bond between the infant and the parent. This gradual development of parenting capacity was a view aligned with the themes for thought reorganisation in Stern's (1995) motherhood constellation.

8.1.3 How do infant services support good relationships between parents with mental health problems and their infants?

Infant services supported the development and maintenance of good parent-infant relationships using a mixture of approaches targeting the implicit and explicit therapeutic gateways in both the individual and the group work modalities. The approaches fostered the development of more pro-social behaviours in parenting striving towards the ideal representations of parent-infant relationships described above. The approaches were consistent with social learning theory, neurobiological research, attachment theory and developmental psychology.

The approaches focused on providing the parents with some avenues to access power to change their own reactions and expression of emotions at either the cognitive or the behavioural level so they had the resources to engage in relationships in a pro-social way. This included offering knowledge on child development and pro-social parenting practices, practical support, facilitating supportive peer relationships, providing validation and opportunities to safely explore new coping mechanisms. Workers also used verbal and non-verbal methods to balance their attention between the needs of parents and the needs of infants, modelling the desired state of mind for parenting. These approaches exemplified the mobilization of co-operative and protective power.

Nonetheless, from the perspective of parents, other approaches like risk management, pro-social modelling and new aggressiveness, could be perceived as mobilizing oppressive and collusive power. This is due to their implications in invalidating socially unacceptable behaviours and identities.

8.1.4 What are the challenges that parents and professionals encounter throughout the process of intervention and how do power implications influence the worker-parent and parent-infant relationships? How do professionals respond to these challenges?

Overall, the challenges related to how experiences of disadvantage, powerlessness and contradictory social expectations had caused mental distress and coping mechanisms in the parents that had detrimental consequences in their ability to engage in relationships with others. These coping mechanisms and the underlying internal struggle for a basic level of access to power to feel secure, were time and again triggered by the care and social control tensions inherent in their relationships with infant services and by the experience of vulnerability in a close relationship to an infant. This was evidenced in the parents' behaviours in response to their mistrust towards services, in their own struggle with disenfranchised feelings, ongoing cyclical patterns of unfulfilling relationships and out of tune interactions with their infants. The parents described displayed sophisticated mechanisms of either avoidance or intrusiveness in how they handled relationships, which in turn compromised the balance of stimulation in their relationship with their infants recommended through attachment theory and neurobiological research.

Professionals and parents also faced the challenges of coping with the competing demands of the needs of parents and infants, and the role ambiguity in infant services resulting from care and social control tensions. Professionals managed the consequent emotional strain using a variety of discourses on role restriction or flexible role perception, self-mystification and risk management. They also accessed emotional support from their peers and supervisors, and engaged in individual reflection while striving for internal coherency in this complex area of work.

8.2 Implications and recommendations for social work practice and education

The findings of this thesis drew attention to the link between structural and individual disadvantage and the effects of the social control and care tensions in the worker-parent relationship in the case of families facing parental mental distress. The possible implications for social work practice of these two issues will be discussed in the following paragraphs

considering two common discourses in social work as identified by the literature, which then will be followed by the recommendations for future practice and education.

These two topics are particularly relevant to social work as examples of two discourses in industrialized Western societies. Following the increasing importance of cross-national identities, national governments in these societies have promoted self-regulation through social policy that favours individual responsibility and the image of the prudent citizen that can avoid risk by abiding the law and the expectations of society (Rose, 1996b.; Kemshall, 2010). In alignment with this development, the rhetoric of risk in social work with children and families has come to the fore in recent decades as a result of several notable child deaths due to child abuse and the perceived failure of the social services to prevent them (Margolin, 1997; McLaughlin, 2010; Stroud, 2011). The same development has been noted in mental health service provision, due to common stereotypes of people suffering from mental health problems as “dangerous”, “incompetent” and “permanently” unwell (Sheehan, Nieweglowski and Corrigan, 2017). Moreover, we have also seen the expansion of the label of ‘vulnerable’ to include greater groups in society and to justify government intervention in their lives through social work (McLaughlin, 2010).

Due to the current political climate that fosters social policies aimed at identifying and reducing risk, social workers can be easily influenced to perceive service users and themselves as workers as being *a risk* or *at risk* (Stanford, 2010). In other words, following this risk atmosphere, workers might be tempted to view identities in the dichotomy of dangerous and vulnerable, independent and dependent, reliable and undependable (ibid.). The abovementioned characteristics of some policies and social work practices can affect the family, consider as a microcosm of the values favoured by society that permit the maintenance of the status quo (Johnstone, 1989). Some of the findings in this thesis can be interpreted as aligned with this risk rhetoric, such as the discourse of infants in need of protection and the risk of child abuse by parents experiencing mental distress. On the other hand, participants also talked about the psychological hazard to themselves of being exposed to parents with dangerous identities (*a risk*) and to infants with vulnerable identities (*at risk*). Non-withstanding the fact that detrimental consequences can come from being exposed to these risks, these examples imply the danger of workers engaging in defensive practice colluding with moral conservatism and assigning these polarized identities to service users and themselves through rigid discourse and practice (Stanford, 2010).

This of course would benefit the dominance of the risk discourse in society, discounting the link between structural and individual disadvantage inherent in these identities (Kemshall, 2010; ibid.). As it has been highlighted throughout this thesis in the power relations analysis and in the social approach to mental distress, this is not a link that can be discounted. The consequences are far-reaching for the individual in their ability to engage with others and for society, as the oppression is supported through collusion.

On the other hand, social workers have been identified as agents of both change and maintenance of the status quo through social control (Margolin, 1997; Clodman, 2004). Stanford (2010) writes that while social workers can choose to support the dichotomization of a risk and at risk identities, they can also choose to challenge these by taking calculated risks themselves allowing their personal and professional vulnerabilities to be part of the relationship with service users. Examples of this were also evident in the findings of this study when workers described their role in a flexible manner and promoted bonding and bridging in group sessions through a non-judgemental environment. This stance of “congruity between the personal and professional identity” together with the continuation of intuitive social work knowledge production through direct practice can enrich social work practice

beyond the boundaries of theoretical knowledge (Fook, Ryan and Hawkins 1997, p. 413). Working in this complex area and in an ambiguous context fraught with intricate power relations issues is a challenge that cannot be understood just through “context-free rules” (ibid., p. 401). This study has highlighted the need for a high level of flexibility and creativity to manage the uncertainty in this complex area of work, which are the marks of social work expertise (ibid.).

In summary, the findings of this study showed signs of the discourse of risk and of the more creative orientation of social work practice. Infant services have the important role of mediating factor to further harm to infants from potentially damaging patterns of interaction with their parents experiencing mental distress, which has been identified as a sign of structural disadvantage. Therefore, the balance between both the risk discourse and the creative orientation in practice needs to be maintained to support both the positive evolution of family dynamics and the protection of infants.

Having discussed the importance of a power relations analysis in infant services practice, the following recommendations are made for social work practice and education:

- There is a need for reflective supervision on power relations, role flexibility and risk issues when working with parents with mental distress experiences.
- The inclusion of this reflection in social work education would contribute to debunking myths about mental health problems and social work practice, and increasing awareness about the potential of role ambiguity in social work with disadvantaged service users.
- Some respondents identified that social work education had not provided enough preparation for vicarious traumatization issues when working to ensure the safety of children. This is definitely an area that needs to be developed further in social work education, as the results of this study revealed its varied effects on different practitioners and its influence on how the work is done.
- For service provision in universal services for infants and toddlers, it would be useful to have clearer guidelines to identify the risk for the infant’s development as a result of invalidating communication patterns with parents with mental distress experiences and the existing protective factors in each family. This information could in turn inform referrals to infant services better and identify the target group for the services more clearly.
- Throughout the interviews, respondents highlighted that due to being non-verbal and having limited people to advocate on their behalf, infants could become invisible in the eyes of policy makers. A view that has also been expressed in other studies on infant services (Malmquist Saracino, 2011). Allowing more flexibility for workers to engage in individual, group work and public advocacy or community work with the same client group, within the same job description and in manageable loads, could provide more advocacy for infants, highlight the link between structural and individual disadvantage and provide more avenues for service users to combat the underlying structures that affect them individually.
- Lastly, this study has highlighted the important and sophisticated role that infant services has in promoting children’s development in risk environments where parents experience mental distress. The proliferation of specialized infant services across all Swedish municipalities could contribute greatly to equity of access and a better start for all infants in the country.

8.3 Limitations of the thesis and recommendations for future research

Finally, we will turn to a reflection on the limitations of this thesis and recommendations for future research in the field of infant services.

This thesis relied on the sole method of data collection of semi-structured interviews in both English and Swedish depending on the language of choice of the participants. For better triangulation of the results future similar research could target some of the access issues encountered here to use other methods like observation and analysis of case notes to validate or challenge the results from the interviews. Furthermore, future research could focus on conducting interviews completely in Swedish for better comparability of the data.

This study focused primarily on asking about individual and group work modalities in infant services work. Nonetheless, the literature has also highlighted the role of social workers on providing educating the community to fight stigma against parents with mental health problems (Clodman, 2004). Future research could also investigate the ways in which infant services challenge or collude with stigmatized representations of parents with mental health problems in society.

The issue of how cultural diversity impacted on the assessment and intervention in infant services was only tangentially discussed, despite the high proportion of families from non-Swedish backgrounds attending infant services in certain municipalities, as reported by participants. Future research could focus on how workers support service users from non-Swedish ethnic backgrounds in comparison to service users from a Swedish ethnic background.

Finally, having analysed the practice experiences from the professionals' perspective, future research could focus on how the mobilization of power in infant services interventions is perceived by service users and children, and how they respond to the challenges of working with services on the parent-infant relationship when facing mental health problems.

9. References

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10. Appendixes

10.1 E-mail of invitation to participate in the study

Dear ...

I am a social work Masters student at the University of Gothenburg with the Erasmus Mundus Masters of social work with families and received your contact details through ... spädbarnsverksamhet. I am originally from Peru, but I am also Australian and have worked as a social worker in Australia for a few years, before I decided to do my Masters. My thesis research is on supporting the development of good relationships between mothers with mental health problems and other difficulties and their babies. I would love to hear about your experiences in the field and learn about how you work in your service from examples of families you have met. I am conducting interviews with workers from spädbarnsverksamheter and mothers attending these services in various places in Göteborg as part of the study.

I would be very interested in attending your service to interview you and mothers who attend the service, on how you work together and the challenges that you encounter. I understand that you might feel more comfortable speaking in an interview in Swedish, I speak intermediate level Swedish and use English for clarification purposes mainly.

I would like to discuss this request with you further if possible, please let me know if you might be available for a short meeting any afternoon 14.00-17.00.

Kind regards

Emiko Matsuo

10.2 Interview guide

Interviews with professionals

General themes for the questions:

- 1 Who accesses the service and why? *Vem kommer till den här verksamheten och varför?*
 - 1.1 What kind of characteristics do the parents have? *Vilka egenskaper har föräldrarna?*
 - 1.2 What are the characteristic that ensure priority over others and why? Please provide some examples. *Vilka egenskaper leder till att familjer prioriteras? Har du några exempel?*
 - 1.3 Who makes the referrals? *Vem skriver remissen? Vem hänvisar föräldrar hit?*
 - 1.4 Is there consensus between workers and families on what the main issue to be addressed is? *Uppnår socionomer och föräldrar samförstånd om vad de ska arbeta tillsammans med?*

- 2 What knowledge and which skills do staff use in this area of work? *Vilka kunskaper och färdigheter används av personalen i den här verksamheten?*
 - 2.2 What is the goal of the work (behavioural, macro level change or cognitive change, change in the system around the caregiver)? *Vad är syftet med arbetet i det här verksamheten (fokuserar man på beteendeförändringar, kognitiva förändringar, förändringar i samhället, förändringar i omgivningen kring föräldrarna)?*
 - 2.3 What does a good caregiver-infant relationship look like? *Hur ser en bra föräldrar-barn relation ut?*
 - 2.4 Do infants contribute to creating this type of relationship? *Bidra späda barn till att bygga ett bra relation med sina föräldrar?*
 - 2.5 How is this goal to be achieved (practical support, through a good relationship between parents and staff, through different therapeutic approaches)? *Hur arbetar man mot syftet (med praktisk stöd, med en bra relation mellan föräldrarna och personalen, med olika terapeutiska metoder)?*
 - 2.6 How does staff conceptualize and connect diversity and parenting? For example: cultural diversity, diversity in family history, in diagnosis and in child temperament. How do staff work with it? *Hur förstår personalen mångfald och föräldrarskap och kopplingen däremellan? Till exempel: kulturell mångfald, olika familj historier, olika diagnoer och barns temperament. Hur arbetar personalen med den här situationen?*
 - 2.7 Are there differences in how the work is done between new workers and more experienced ones in the organisation? *Finns det skillnader mellan hur ny personal och erfaren personal arbetar i verksamheten?*

- 2.8 What type of relationship with the caregiver is needed in this area of work and why? What is the role of this relationship? How do you achieve that relationship? *Vilken sorts relation mellan personal och föräldrar behövs i den här verksamheten och varför? Vilken roll spelar denna relation? Hur uppnår man det?*
- 2.9 How are skills and knowledge connected and put into practice? Can you provide examples? *Hur kopplas kunskaper och färdigheter samman och omsätts i praktik? Har du några exempel?*
- 3 How does staff face challenges in this area of work? *Hur hanterar personalen utmaningar i verksamheten?*
- 3.2 How are challenges conceptualized? *Hur förstår personalen utmaningar?*
- 3.3 How does staff work with time management? *Hur hanterar personalen tidsplanering?*
- 3.4 How is trust built in the relationship between parents and staff? *Hur utvecklas förtroende i relationen mellan föräldrar och personal?*
- 3.5 Is shame a relevant concept for the parents that come here? *Är skam relevant för föräldrarna som kommer hit?*
- 3.6 Are there challenges in changing a well-established pattern of thinking or doing? *Finns det utmaningar när man försöker att förändra väl etablerade beteendemönster?*
- 3.7 How did the parent handle these challenges? *Hur hanterade föräldrarna de här utmaningarna?*
- 3.8 How did you react to these challenges? In hindsight and thinking realistically, would you have done anything differently? *Hur reagerade du mot utmaningarna? Om du kunde, skulle du vilja göra något på ett annat sätt?*
- 3.9 Professions and services develop dynamically across time. How do you think staff will work with parents in 5 years? *Yrken och verksamheterna utvecklas dynamiskt över tid. Hur tror du personalen kommer att arbeta med föräldrarna i 5 år?*

10.3 Consent form

Informed consent

The following is a presentation of how I will use the data collected in the interview. In order to ensure that projects meet the ethical requirements for good research I promise to adhere to the following principles:

- Interviewees in the project will be given information about the purpose of the project.
- Interviewees have the right to decide whether they will participate in the project, even after the interview has been concluded.
- The collected data will be handled confidentially and will be kept in such a way that no unauthorized person can view or access it.

The interview will be recorded as this makes it easier for me to document what is said during the interview and also helps me in the continuing work with the project. In my analysis, some data may be changed so that no interviewee will be recognized. After finishing the project, the data will be destroyed. The data I collect will only be used in this project.

You have the right to decline answering any questions, or terminate the interview without giving an explanation.

You are welcome to contact me or my supervisor in case you have any questions (e-mail addresses below).

Student name and e-mail

Emiko Matsuo

Emiko.matsuo@hotmail.com

Supervisor name and e-mail

Staffan Höjer

Staffan.hojer@socwork.gu.se

Interviewee signature

Skriftligt samtyckformulär

Det här dokumentet berättar om hur jag ska använda information från intervjuer. Jag lovar att följa följande principer som bygger på de etiska kraven för god forskning:

Personer som intervjuas i projektet kommer att ges information om projektets syftet. Personer som intervjuas i projektet har rätt att avgöra om de kommer att delta i projektet, även efter att intervjun har avslutats.

Den insamlade informationen kommer att vara konfidentiell och kan inte visas för obehöriga personer.

Intervjun kommer att spelas in, så att det är lättare för mig att skriva exakt vad som sades i intervjun. I min analys, kan en del data komma att ändras så att alla intervju personer förblir anonyma. Efter projektet avslutande, kommer all data att förstöras. De uppgifter jag samlar in kommer endast att användas i det här projektet.

Du har rätt att avböja att besvara alla frågor, eller avsluta intervjun utan förklaring.

Du är välkommen att kontakta mig eller min handledare om du har några frågor (e-postadresser nedan).

Student

Emiko Matsuo

Emiko.matsuo@hotmail.com

Handledare

Staffan Höjer

Staffan.hojer@socwork.gu.se

Underskrift, intervjudeltagare